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The Journal

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Canada plans focus on marijuana in $2.1m drug education proposal

By Dick MacDonald

TORONTO — The federal government is preparing to launch a three-year, $2.1 million drug education campaign in March, aimed at teenagers and their parents.

The campaign, nearly two years in the making, will be conducted principally through television commercials and magazine advertisements. While the campaign will deal with all substance abuse, emphasis will be on cannabis.

Lori Jones, communications officer with the health promotion directorate of Health and Welfare Canada, told **The Journal** the campaign's messages will be restricted to health issues.

"We are not entering legal or political areas," she said.

Target audience for the campaign is the 12 to 19 years age group, to be reached primarily through television. Parents, seen to be more print-oriented than youth, will be reached primarily through magazines. While newspapers are still being studied for possible use, Ms Jones said radio would not be included in the campaign.

No catch-phrase has been devised, she said, "but we want to get across the notion of 'being yourself,' " The campaign "will not be preachy" but will clearly suggest that it's best to "stay clear of substance abuse."

She said the approach to be used in the TV commercials and print ads "is to lay out the facts without moral messages. This isn't a scare campaign."

The directorate intends to spend $700,000 over each of the next three years. Health and Welfare Minister Monique Begin must give final approval to the campaign, but preparation began after she gave the go-ahead to preliminary concept proposals.

As it now stands, the government will spend less on the cannabis awareness program than it has on either its Dialogue on Drinking or The Generation of Non-Smokers campaigns, each of which cost $1 million a year.

Ms Jones said the campaign will include a pamphlet on cannabis which will be offered through the TV and print ads. "We're also looking for peer-to-peer distribution of the information if it is to be truly credible," she said.

The directorate also is revising an existing booklet, *A Parents' Guide to Drug Abuse*, possibly under a new title.

Ultimately, Ms Jones said, the campaign aims to get across the message "that it's okay *not* to smoke dope, that teenagers do have a choice, that they don't have to yield to peer pressure."

She said the focus audience of 12- to 19-year-olds was identified partly through a survey conducted for Health and Welfare in early 1982 by Gallup Polls. The survey showed that 26% of people in that age group had used marijuana at some time; only 6% had used it in the previous week.

Marijuana: 10 years after LeDain

The Back Page

Exploitation occurs too easily: Sartorius

International projects need rules

By Betty Lou Lee

OAKLAND, CA — A set of ground rules for collaborative international work, including ones which would prevent exploitation in developing countries, has been suggested by Norman Sartorius, director of the mental health division of the World Health Organization (WHO).

"Ethically reprehensible behavior can occur particularly easily" when collaborative research involves those in developing and highly developed countries, he said here in his keynote address at an international meeting on substance abuse.

Sartorius: sad but true stories

"The investigator in a highly developed country often has well-established data-analysis facilities and staff who can give advice on methodology; speaks and writes fluently one or more languages in which the most widely-read journals are published; has access to colleagues and collaborators whom he can ask for advice and criticism; usually has library facilities; and often works in a setting with a long tradition of scientific work of high quality," Dr Sartorius said.

"Scientists are not immune to generally-held prejudices, and have plenty of their own. Among them, perhaps the most harmful are those about the predictive value of 'low-quality' work published in developing countries, which is taken as an indicator of their capacity, rather than as a result of a mixture of factors such as poor quality of printing services or the lack of access to current literature.

"The result is frequently . . . a paternalistic attitude in planning, meeting, analyzing data, and publishing the results," Dr Sartorius said. "The researcher in the developing country becomes a faithful data collector, who is offered authorship in some publication from studies, but has no real say in the selection of topics, points of emphasis, or place of publication."

One of the principles suggested by Dr Sartorius is that investigators work together and share their tasks on an equal basis, with joint publications the rule.

The rules of the ethical committee of the country with the strictest regulations should be enforced in all countries involved, he said.

"Sad but true stories of experimentation abroad, of brain biopsy material being shipped to developed countries' laboratories, and of unpublished failures of treatments attempted in a centre outside the country in which such treatments would not have been allowed, are many," Dr Sartorius said.

"There is no way that control could be induced if investigators themselves are not committed to enforcing controls and act accordingly."

The solution to any problem being studied must be of clear relevance to the needs of all the centres, agencies, and countries participating, and the process of collaboration should be useful to all the parties involved.

None of the parties should be harmed by the collaboration.

"This is easier said than done," Dr Sartorius said. "Direct harm, and immediate harm, can of course be easier to recognize and prevent. It is the indirect and

(See — Collaboration — page 2)

Heroin addiction on rise in UK gov't action seen as necessary

By Alan Massam

LONDON — The combination of high youth unemployment and ready availability of illicit supplies has pushed heroin addiction here to the point where the government will have to act.

That was the verdict as field workers awaited publication of a report from the Advisory Council on the Misuse of Drugs.

Connell: draws attention

The council is expected to recommend a massive increase in welfare provision for addicts, particularly in the capital, and tighter controls on family physicians whose overprescribing of saleable heroin substitutes is blamed for financing street sales of the real thing.

The Advisory Council on the Misuse of Drugs is urging a restructuring of the State clinic system for prescribing heroin set up in the late 1960s after addiction had grown alarmingly.

It is now widely recognized that these clinics, which held the line at the time, have ceased to be effective.

They are thought to see only a small proportion of addicts because official policy of weaning off heroin is so unpopular and illicit supplies of the drug are now much greater.

Jasper Woodcock, director of the Institute for the Study of Drug Dependence here, told **The Journal**: "The State clinics have also suffered from cuts in National Health Service expenditure until they are now attempting to do twice the work with much reduced facilities.

"It has been evident for some time that they are unable to cope."

Mr Woodcock said that despite the government's stated intention of reducing welfare spending it seemed there was real concern about hard drug addiction. It therefore seemed likely money would be spent to contain the problem.

Much credit for drawing attention to the growing problem of heroin addiction in Britain must go to Philip Connell, director of the drug dependence clinical research and treatment unit at the Maudsley Hospital, south London.

Dr Connell began campaigning for improved facilities when the Home Office published statistics of known heroin addicts in Britain last June. These showed that the number of registered addicts in 1981 was 3,800 compared to 2,846 at the end of 1980. These figures are known to represent only the tip of the iceberg since the majority of addicts are now unregistered. But the increase is thought to reflect accurately the percentage growth of the problem.

INSIDE

NEWS

Briefly. . .

Soccer fans stampede

CALI, Colombia — Twenty-four people, including 14 children, were killed and 250 injured recently after drunken fans provoked a stampede in the soccer stadium here. Police said drinkers in the higher stands of the stadium hurled lighted firecrackers and bottles and started urinating on people leaving the area at the end of a game. "Their behavior started a rush to the exits and at least 24 people were killed in the stampede to get out," a police spokesman said.

Watch that camera

SYDNEY — Cigarette billboards at sporting events could become a thing of the past here if the Australian Medical Association has its way. The association has asked the government to include a provision in the Broadcasting and Television Act that stations be required to take "reasonable care" to ensure that they do not screen cigarette billboards when they televise sporting events. "The effect would be to force sporting bodies to abandon cigarette advertising on their grounds if they wished their events to be televised," said Dr George Repin, the association's secretary-general.

NCA on defence

LONDON — The Earl of Kimberley, chairman of the British National Council on Alcoholism and a recovered alcoholic, has vowed to try to stop the government from disbanding his group. Lord Kimberley hopes to secure funding for the NCA from industry, but in the meantime will try to convince officials that years of infighting within and among the NCA and other voluntary organizations can be swept away. A government-sponsored report has criticized these groups and recommended a new national body be formed. No action has been taken yet, but the government has not made a commitment for future funding to the groups, either.

Acupuncture success

SAN FRANCISCO — Accupuncture has a 30% success rate in curing heroin addicts, the Haight-Ashbury Free Medical Clinic has found. This is double the clinic's usual rate with medical treatments, and much more impressive than the overall national average of about 4%. Since 1975, 200 addicts have completed the 21-day treatment program of accupuncture combined with counselling. But it doesn't work for everyone. Ninety per cent of those who started the treatment dropped out, and workers have had a hard time convincing many addicts to try it.

Buying a round

REGINA — It's now legal to buy a round of drinks in licenced facilities in Saskatchewan. The provincial Cabinet repealed regulations in November which had made the practice against the law. Until the order-in-council was passed, individuals in a club, bar, or cocktail room could only buy beer, spirits, or wine for themselves.

FAS-like symptoms seen in pot-smokers' newborns

BOSTON — Women who used marijuana during pregnancy delivered infants that had a five-fold greater risk of having symptoms considered compatible with the fetal alcohol syndrome (FAS), a study reveals.

"What was unique about our study findings was the relationship we observed between maternal marijuana use during pregnancy and lower infant birth weight," says Ralph Hingson, ScD, co-ordinating analyst of the study and author of the report. "Taking into consideration all other maternal characteristics . . . women who smoked marijuana . . . delivered babies about 100 grams smaller."

In addition, the more often the mothers smoked marijuana the smaller were their babies, he says.

Women who smoked marijuana three or more times per week delivered babies that were 139 grams on average lighter than babies of women who didn't.

The investigators also found that the maternal factor most highly associated with infant characteristics considered compatible with the fetal alcohol syndrome was whether the mother had smoked marijuana. In their study population, women who smoked marijuana during pregnancy were five times more likely to have delivered infants with features compatible with FAS.

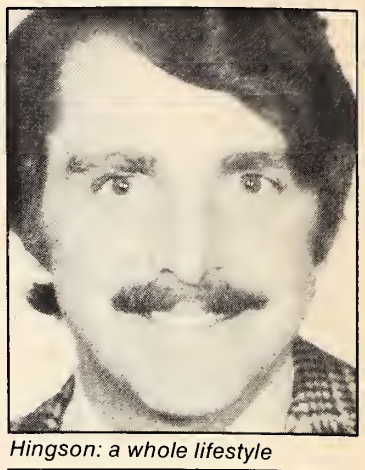
The study is among the first to reveal a detrimental impact on the fetus of maternal marijuana use. In 1981, Canadian scientists reported that a woman who smokes as few as five marijuana cigarettes a week during pregnancy can affect the functioning of her baby's central nervous system (**The Journal**, May, 1981).

The study was based on the hypothesis that pregnant women who drink heavily are likely to engage in other behavior that could be harmful to their unborn children.

Between 1977 and 1979, a team of pediatricians and pediatric neurologists examined 2,514 infants at Boston City Hospital. The investigators interviewed 1,690 or 67% of the mothers. The pediatricians rated each infant for length of gestation, birth weight, body length, head circumference, and congenital abnormalities.

They also classified infants according to presence of any features compatible with FAS, based on criteria developed by Drs James Hanson and David W. Smith of Seattle, pioneers in the description of this syndrome.

The mothers were asked about variables thought to influence fetal development, including the use of psychoactive substances, cigarette smoking, education level, prenatal care, their height and weight, and weight gain during pregnancy.



Hingson: a whole lifestyle

Of all the variables studied, lower maternal weight gain was most consistently associated with adverse outcomes such as shorter length of pregnancy, smaller infants, congenital malformations, and the presence of symptoms compatible with FAS.

The mother's history of illness during pregnancy, drinking alcohol before and during pregnancy, and maternal cigarette smoking were other factors which affected either length of gestation or infant size, the study found.

The study also showed that the relationship among marijuana use, small infant size, and the presence of FAS-like symptoms existed among cigarette smokers and non-smokers, drinkers and non-drinkers, and among mothers who smoked and drank, and those who did neither.

"So it was quite consistent that regardless of which of these other habits women engaged in, women who smoked marijuana during pregnancy delivered smaller babies and were more likely to have babies with symptoms compatible with fetal alcohol syndrome than those who did not," Dr Hingson says.

He added it is short-sighted to say that one factor, such as drinking, or cigarette or marijuana smoking is the most decisive. "What we are picking up is that there seems to be a whole lifestyle that is involved."

He says further studies replicating these findings are needed.

Dr Hingson is an associate professor, Boston University (BU) School of Public Health and department of Socio-Medical Sciences and Community Medicine. The study was headed up by Dr Joel Alpert at the BU School of Medicine and Boston City Hospital.

Diagnostic tool for high risk kids?

Drinkers' sons show brain shifts

By Betty Lou Lee

OAKLAND, CA — Some sons of alcoholic fathers have changes in the limbic area of the brain similar to those found in adult alcoholics.

"This opens up an exciting possibility, a potential for diagnosing kids at high risk and developing intervention procedures," says Henri Begleiter, PhD, a neurophysiologist and professor of psychiatry at the State University of New York, Downstate Medical Centre in Brooklyn.

"We think it may be a predisposing factor," he says.

Dr Begleiter used evoked brain-potential techniques to record the speed and strength of electrical messages in the brains of 18 boys aged six to 12 years who had alcoholic fathers but had never used alcohol or other drugs themselves.

"A number of brain deficits have been found in sober alcoholics who have been drinking for years . . . at various levels of brain function," Dr Begleiter told **The Journal**. "It was assumed they were all the consequence of many years of alcohol abuse.

"We began to look at children at high risk for alcoholism, sons of alcoholic fathers. We found some, not all, had neurodeficits identical to adult alcoholics . . . . But not all sons of alcoholics become alcoholics, only 20 to 30% do."

Dr Begleiter: "These deficits are only in the limbic system, which is critical to appropriate emotions and memory. They are strikingly similar, if not identical, to those found in adults. There are a number of other deficits in adults that we didn't find in the children, and they may be a result of drinking."

The children with these changes tend to be in the low average range at school. "There are no super achievers," he said. Their teachers tend to describe their behavior as more active, volatile, or temperamental.

Dr Begleiter admits the finding is one that asks more questions than it answers.

He is trying to test some of the boys' fathers to determine if the father-son limbic patterns are identical.

Even if they are, it would still not answer the question whether the fathers themselves inherited the pattern, developed it spontaneously, or developed it after drinking.

There is also the question of what to tell the boys, who are being followed every year, and their parents, without affecting any outcome in drinking patterns among the children.

Because of the selection criteria used for the children, it has taken two years to enrol just 18. There must be a confirmed diagnosis of alcoholism in the father, the family must be intact, the mother must not be an alcoholic, and she must not have used alcohol during her pregnancy.

Dr Begleiter discussed his findings at An International Perspective on Substance Abuse, held here by the Association for Medical Education and Research in Substance Abuse and the World Health Organization.

Collaboration takes effort

(from page 1)

delayed effects which deserve most attention."

One example is the injection of a lot of money into a developing country so that all qualified people move into the field of drug dependence, depriving the mental and general health-care fields of everyone trained in psychiatry and the behavioral sciences.

Any project should leave behind a framework useful for future joint work, he said.

"Considerable effort has to be invested in building up possibilities for collaboration. This includes the development of a common language, of instruments, of specially trained people, of an atmosphere of readiness to work together . . . If this is done for a single project or for a brief time it is usually wasteful. Few countries can afford waste."

A collaborative project shouldn't exhaust the resources of a centre or a team, so it has nothing in reserve for its normal tasks or other opportunities.

"Collaborative activities should fit the culture into which they are being introduced. Changing the environment to make a technique work has been attempted on many occasions, and usually resulted in damage to socio-cultural balance and a failure of the technique," Dr Sartorius said. "Conversely, forces of culture are underused. In this respect, the field of substance abuse is a resplendent cemetery of missed occasions."

Dr Sartorius was speaking to 200 representatives of 15 countries in a week-long conference sponsored by the Association for Medical Education and Research in Substance Abuse (AMERSA) and the WHO.

Co-sponsors were the Addiction Research Foundation of Ontario, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the Career Teacher Program in Alcoholism and Drug Abuse, and the State University of New York Downstate Medical Centre.

One of three considers drink causes trouble

NEW YORK — One of three people in the United States believes drinking has caused problems in his or her family, and 81% say alcohol abuse is a major national problem, according to a recent Gallup survey, announced in a press conference here.

The survey, sponsored by Comprehensive Care Corporation, found 79% of people polled agreed with the statement that alcoholism is a disease that should be treated in a hospital; 63% agreed with a similar question in 1955. Only 42%, however, would advise a family member or close friend with a serious long-term alcoholism problem to go to a hospital treatment program for help.

NEWS

Turner says research still needed

EAPs have high payoff

By Harvey McConnell

PHILADELPHIA — Employee assistance programs (EAPs) have come a long way in a short time in the United States, but there is still need for sophisticated research and help from the federal government.

And the need for early and active intervention for those with substance abuse problems must be applied in government agencies as it has been in industry, believes Carlton Turner, director of the White House Drug Abuse Policy Office.

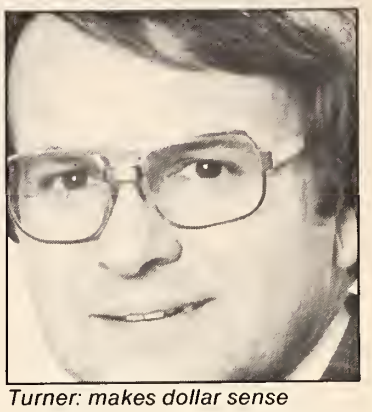
Dr Turner told the annual meeting of the ALMACA (Association of Labor Management Administrators and Consultants on Alcoholism) here that for delegates who flew to the conference, the skies were safer than a few years ago because of cooperation between two government agencies — the National Institute for Alcohol Abuse and Alcoholism (NIAAA) and the Federal Aviation Administration (FAA) — and the Airline Pilots Association.

"Today pilots need not deny they have an alcohol problem, and they can obtain treatment without losing their jobs."

Dr Turner said early intervention makes dollar sense as well, and must be effective as 57% of Fortune 500 companies (the top 500 US industrial companies in terms of sales volume) now have EAPs. Companies report significant cuts in work hours lost and in disability payments "and this means that all of society benefits."

Dr Turner said: "The federal government must help to sustain the achievements made by occupational programs over the last decade. These programs have a very high payoff."

One problem at present, he said, is that since companies implement an EAP on a voluntary basis, they decide what constitutes the definition of a program. This makes it difficult to find benchmarks in this relatively new field.



Turner: makes dollar sense

Many people operating EAPs also need training to provide a high quality service. He said NIAAA has developed a curriculum to provide such help.

Dr Turner said research and evaluation may present another problem, and more sophisticated research must be developed. Some programs have no access to research data.

Inmate moms set double standard, want drug-free life for children

By Mark Kearney

TORONTO — Many inmate mothers who have used drugs lead a "schizophrenic lifestyle" to try to prevent their children from following in their footsteps, says a Washington, DC, social science analyst.

"The demands of a drug habit ultimately collide with the demands of children," said Phyllis Jo Baunach, PhD, of the United States National Institute of Justice, in a paper presented to the American Society of Criminology annual meeting here.

"Therefore, over and above the shame they feel because of their crime, conviction, and separation due to incarceration, these mothers have an additional burden of guilt to bear.

"The inevitable conflict resulting from these incompatible demands leads to what I have called a schizophrenic lifestyle — junkie by day and mother by night, or vice versa."

In what is believed to be the first study of its kind, Dr Baunach found that 43.6% of 126 inmate mothers in the states of Washington and Kentucky said they had sold and/or used drugs or had been alcoholics prior to incarceration.

Her study showed many mothers didn't use or sell drugs in front of their children. Some pretended to be "sick" with diabetes if discovered by their children to be injecting themselves, she says.

To avoid discovery, mothers would either go to a friend's house or wait until their children were at school or asleep before taking drugs, Dr Baunach says. Some mothers felt embarrassed about trying to explain their drug use to the children, or wanted to avoid any questions about it.

"For whatever reason, inmate mothers uniformly said that they did not want their children exposed to a life of drugs."

She says such children often view their mothers as friends or siblings, and the mothers often have feelings of ineffectiveness in disciplining the children.

Baunach: burden of guilt

Supreme Court upsets previous rulings— 'magic' mushrooms themselves are illegal

By Eleanor LeBourdais

COURTENAY, BC — The Supreme Court of Canada has decided "magic" mushrooms themselves are illegal, and not just the psilocybin they contain.

Schedule H of the Food and Drugs Act outlaws psilocybin, the active ingredient in the *psilocybe mexicana* and in some other species of mushroom, but says nothing about mushrooms themselves.

The Supreme Court's finding upsets previous rulings by both a trial judge and a BC Court of Appeal that the mushrooms themselves are not a restricted substance. (**The Journal**, July, 1982).

In a 1980 case, a Courtenay man was charged with trafficking in psilocybin after he unknowingly sold a pound of "magic" mushrooms to two undercover Royal Canadian Mounted Police officers for $3,000. The trial judge concluded that mushrooms are not restricted and the man was acquitted.

Possession of mushrooms has been considered legal by police since 1979, when BC Chief Justice Nathan Nemetz ruled that although refined psilocybin is covered by the Food and Drugs Act, mushrooms are not.

Most successful prosecutions have been for the provincial offence of trespassing, with charges being laid against mushroom pickers who venture on to private property. Recent amendments to the Trespass Act were successful in discouraging some trespassers, but the Courtenay RCMP detachment alone issued charges against more than 30 individuals this year.

Courtenay RCMP constable Lou Goulet says the Supreme Court's finding will give police an additional tool for enforcement. Mushroom pickers may be charged with trespass and also with possession of a restricted drug — psilocybin.

However, despite the new ruling, prosecutors may continue to have difficulty applying the law, because not all mushrooms in the same area always contain the drug. Soil and climate variations influence the production of psilocybin in the five species of potentially-hallucinogenic mushrooms which may be found growing wild in BC.

Looking back at Aku-Aku—the sparkle's gone

By Wayne Howell

It has been more than two years since I have written about Aku-Aku in this column; and readers might well conclude that I have lost interest in that south Pacific island. Not so. I still follow developments there as closely as I can. I suspect that I have not written about Aku-Aku because, well, to be perfectly frank, Aku-Aku is not really the interesting place it once was.

Back in the 1970s when Aku-Aku first encountered the modern world and modern drug problems, there was a certain slapstick quality to events on Aku-Aku as the King rushed about madly trying to apply the various solutions recommended by visiting advisors from the developed world. Now that the guano industry has made Aku-Aku a virtual Polynesian Kuwait, and has allowed the King the luxury of developing the institutional infrastructures necessary to deal with Aku-Aku's drug problems once and for all, developments on Aku-Aku have become predictable and mundane. Not the sort of stuff that would titillate the readers of **The Journal**. Perhaps the simplest way to illustrate this is to review the events of the past year in Aku-Aku on a month-to-month basis.

January was generally pretty boring, except for the annual convention of the Aku-Aku Alcohol and Drug Institute (AAADI). Things of great moment and projects of great merit were allegedly discussed. Unfortunately, economic exigencies prevented the publication of an official transcript or report, so this rumor has yet to be verified. (Funding for socially useful programs is a perennial problem in Aku-Aku, despite the recent affluence. As the chairman of the AAADI said, "we were lucky to get the money to go to the convention.")

February was a short month, but despite its relative brevity it was not without interest, for this was the month in which the AAADI finally decided to forget past animosities and make common cause with the AADAI (Aku-Aku Drug and Alcohol Institute). This fortuitous coming together had actually had its beginnings in late January, when delegates returning from the aforementioned AAADI convention in Casablanca and delegates returning from an AADAI conference in Geneva found themselves stranded together for a day in the departure lounge of the Singapore airport. There, they slung together an agreement. As a result of the 'Singapore Agreement' the two institutions announced, on February 23, 1982, that a war was going to be declared.

March came in like a lion. There was much conflict as the AAADI, the AADAI and the NAAIAD (National Aku-Aku Institute of Alcohol and Drugs) struggled with the question of what to declare war upon. The AAADI immediately betrayed its origins (it had started life as the AAAAA — Aku-Akuans Against Alcohol Abuse) by pushing for a war on alcohol. The AADAI was adamant that the war should be against a drug, preferably an obscure one, so there would be some small hope of victory. The NAAIAD tried to compromise by suggesting a war on alcohol and drugs, and herpes too, for good measure. This was not well received, and March went out more or less the same way it had come in.

The AAADI spent April in Paris. But that is not why April is remembered in Aku-Aku. April is remembered as the month the King took matters into his own hands and declared war on the neighboring island of Fungi.

Nothing happened at all in May. That is to say, the NAAIAD held its annual meeting in Stockholm.

June saw the Aku-Akuan flag proudly waving from the peak of mount Fungora. Fungi had been taken with minimal casualties. A grand victory parade was held and people threw flowers at the King as he rode through the capitol of Aku-Aku in an open car. The King did not regret his decision. "A war can be brought to a much more satisfactory conclusion when the enemy is them rather than us," he said.

July passed without incident. Perhaps there might have been an incident, had the AAADI's scathing denunciation of the government's tight-fisted monetary policy come to light, but after travel expenses had been taken care of (Aku-Aku — Vancouver — Aku-Aku) there were insufficient funds to pay for the printing and distribution of the AAADI indictment.

August is a mystery month. Either the NAAIAD did not publish its newsletter or it was lost in the mails. I suspect the former, which would indicate that nothing happened.

September saw a dreadful squabble break out in the AADAI over a resolution demanding that future speakers at AADAI conferences have something new or original to say. The radical group that propounded this resolution was soon brought to heel by more thoughtful members of the institution, who pointed out the impracticality of the proposal; not only would it be extremely difficult to find such a speaker, but, if such a speaker were to be found, delegates would be under some obligation actually to sit and listen to him, and that would be a drag. This kind of sensible talk eventually brought the radical group around.

October was the month the long-awaited Aku-Aku National Assembly Comprehensive Report on Drugs and Alcohol appeared. Its final conclusion — that the immoderate use of drugs and alcohol was bad and something should be done about it — caused a flurry of activity.

In November this flurry of activity came to a head. The AAADI, the AADAI, and the NAAIAD held a joint conference to discuss the broad-reaching implications of the National Assembly report. To highlight the seriousness of the situation, they held it in Aku-Aku. Funds were thus available to expedite the printing and distribution of their report. It was ignored.

I do not have all the details on December's activities as yet, but I understand that December was the month in which the 'Singapore Agreement' broke down and the AAADI and the AADAI resumed their fratricidal squabbling. Apparently the King had to send the whole lot of them to San Francisco for a week to set things right.

NEWS

RESEARCH UPDATE

I don't want a cigarette

Young teenagers who already smoke or indicate they will probably start are much more likely to have an external than internal "locus of control," suggests a study of 1,300 Vermont seventh-graders. The difference is potentially important to smoking prevention programs, explain researcher John H. Clarke and colleagues from the University of Vermont; influencing "externals" — those who tend to feel themselves somewhat fatalistically in the sway of external forces — is different from influencing "internals." Smoking prevention programs tailored more to these higher-risk "externals," the researchers say, might focus on the immediate advantages of nonsmoking rather than future disadvantages such as health effects; rely more on experience and sensation than on factual information; and provide substitute activities that are immediately pleasurable. Programs for young teens should also try to activate peer group pressures against smoking, they suggest, by presenting refusing to smoke as an act of adolescent resentment and rebellion against older peers, older siblings, parents, and media.
Journal of Health and Social Behaviour, 1982, v. 23:253-259.

Drugged driving also dangerous

Driving after marijuana use is associated with a sharply increased risk of being involved in accidents, indicates a study of nearly 6,000 teenagers aged 16 to 19 years. The study was done through an anonymous telephone survey in which the respondent was asked how many times in the previous month he or she had driven after drinking, smoking marijuana, or using psychoactive drugs, and how many driving accidents the respondent had been in during the previous year. It found those who drove at least six times after smoking marijuana (without drinking or taking psychoactives) were 24 times more likely to have been involved in accidents than were those who did not mix marijuana and driving. Similarly, those who smoked and drove on at least 15 occasions in the previous month had nearly three times the accident risk of those who drove the same amount but didn't mix marijuana and driving. Analysis showed, say researchers Ralph Hingson and colleagues, the increased risk of driving after marijuana use was comparable to that of driving after drinking.
Journal of Safety Research. 1982, v.13: 33-37

Clonidine works

The first Canadian study of Clonidine therapy for narcotic withdrawal supports United States and British studies which have shown Clonidine is effective as long as the patients involved are strongly motivated. Dr Paul Devenyi of the Addiction Research Foundation, Toronto, with Drs Ahmed Mitwalli and Wendy Graham, describes four cases in which individuals were withdrawn from dependence on short-acting narcotics (including Percodan, Dilaudid, and Tussionex.) Once on Clonidine, none of the four showed any further signs of withdrawal symptoms, and each was discharged after approximately 10 days of treatment. The researchers caution, however: "It is difficult to foresee much outpatient use of the Clonidine regimen, not only because of the compliance problem, but also because of potential interactions between opiates [which might be available to the patient] and Clonidine, possibly leading to such side effects as sedation and hypotension."
Canadian Medical Association Journal, Nov. 15, 1982: 1009-1011.

Parents play drinking role model

A study of the relationships between the alcohol-use patterns of parents and their children (18 years or over) suggests offspring imitate their perception of their parents' drinking, with a particular emphasis on imitating the same-sex parent as long as the parental drinking is seen as being moderate. The imitation drops off sharply if the parent is seen as being either an abstainer or a heavy drinker, say researchers Ernest Harburg, Deborah Davis, and Roberta Caplan, all of the University of Michigan. The study, based on 1,153 interviews with residents of a small, midwestern town, suggests the "aversive" response on the part of a son or daughter is most likely to occur against the abstaining or heavy drinking of an opposite-sex parent.
Journal of Alcohol Studies, 1982, v.43:497-515

Alcohol information overload

Nearly three-quarters of alcoholism treatment professionals find it difficult to keep up with what is going on in their field, suggests a survey of 99 Minnesota alcoholism specialists. The survey asked the specialists how much information overload they were experiencing and how they ranked the usefulness of methods of information-gathering, including face-to-face interaction (training sessions and workshops, consultation with colleagues, staff conferences, and local conferences); conferences (at the regional, national, and international levels); and reading (including journals, newsletters, books, pamphlets, and material from clearinghouses). The top spot was given to training sessions and workshops, the second to consultation with colleagues, third to journal articles, and fourth to newsletters. Local conferences and staff conferences took the fifth and sixth spots respectively. Face-to-face interaction is clearly the most important mode of information gathering, the researchers say, with reading falling in the middle (though books and pamphlets aren't seen as important) and conference-going coming last (regional, national and international conferences ranked eighth, 10th, and 12th respectively).
Journal of Studies on Alcohol, 1982, v.43:5

Austin Rand

Professional disinterest spurs trend

Self-help groups on rise

By Betty Lou Lee

OAKLAND, CA — In the very era that more scientific information about substance abuse has become available, there is a trend away from professional involvement in its treatment.

McGill University psychiatrist Juan Carlos Negrete pointed out this paradox at the opening session here of An International Perspective on Substance Abuse, citing the growth of the self-help group movement and of non-professional rehabilitation facilities in the past 40 years.

Dr Negrete is director of the alcohol and drug dependence unit at Montreal General Hospital.

In those 40 years, he said, important scientific advances include the discovery of opiate antagonists in the 1940s, of effective therapeutic drug substitution and identification of sites of action in the 1960s, and the discovery of opiate receptors and of endogenous opiate peptides in the 1970s.

But these findings "have done little so far to motivate professionals, beyond the relatively reduced circle of laboratory researchers and specialized clinicians."

At the same time, "disinterested or rejecting medical attitudes" toward abusers have no doubt influenced the development of non-professional involvement in rehabilitation, Dr Negrete said.

These attitudes by health professionals were a recurrent theme throughout the week, as 200 experts on substance abuse from 15 countries pondered how to improve education and motivation in the field. The conference was sponsored by the Association for Medical Education and Research in Substance Abuse and the World Health Organization.

"In spite of the severe criticism directed to health professionals for allegedly monopolizing the field of substance abuse, the evidence indicates there is a tradition of medical neglect in this area," Dr Negrete said.

He noted that as late as 1956 the American Medical Association urged hospitals to offer alcoholics the same services as other patients.

When they do become involved with abuse, professionals don't act on the basis of globally-accepted standards, but are influenced by the cultural views of their communities, he noted.

"In fundamentalist Moslem societies, for instance, alcohol users whose patterns would not be considered abusive elsewhere are thought to need corrective treatment.

"Of course, many of the intervening professionals are aware of the different criteria followed in other societies to handle similar cases, but they still feel it their duty to act in accordance with the local social climate."

If they go along with a culturally-determined requirement for treatment, they also go along with cultural acceptance of dependence.

"Few local physicians would consider it warranted to intervene in cases of Khat dependence in North Yemen, or of coca leaf chewing in the Andean highlands, or, indeed, in cases of chronic Ayahuasca intoxication in the Peruvian jungle.

Negrete: negative attitudes

"This, in spite of the fact that in these same locations the abuse of prescription stimulants or of synthetic psychodysleptics would certainly be thought to require professional intervention."

Dr Negrete said poor therapeutic response by abusers plays a role in physicians' negative attitudes toward them.

"Doctors generally experience difficulties in accepting disorders which are not self-limiting, follow a prolonged course, and cannot be totally corrected by their intervention.

"The problems of relapse, residual deficit, and partial handicap are facts of medical practice which appear to be better tolerated in conditions other than substance abuse. The unrealistic therapeutic expectation of complete restitution, and the inability to view improvement of function as a positive outcome in the latter, are clear evidence of a lingering moralistic perception of the problem."

Law reformers urge new intoxication crime

TORONTO — A new offence of "criminal intoxication" has been proposed by the Law Reform Commission of Canada to help cope with the problems of crimes committed by people under the influence of alcohol or other drugs.

The proposal suggests "no one who allows himself to be a source of danger to others should be let off scot-free."

It is included in a working paper released recently by the commission on reform of the general part of the Criminal Code. The paper is intended to stimulate discussion and criticism before the commission submits its proposals to Parliament.

The commission proposes that, under the reform, offenders intoxicated by alcohol or drugs should not be convicted of the crime of which they were accused if they lacked the necessary intent to commit it.

"Instead (they) should be convicted of that for which they are really to blame — getting so intoxicated as to be dangerous to others."

Intoxication could be used as a defence against the crime in question, the commission says, but "as soon as an accused explains that the crime resulted from his being intoxicated, he . . . may be liable to conviction for criminal intoxication."

The commission has questioned the logic of the current law which recognizes intoxication as a defence for certain crimes but not others: namely crimes which the law considers to have specific intent but not those of general intent. Such distinctions are difficult to comprehend and apply, the commission notes.

The only defence against criminal intoxication as proposed by the commission would be that it was involuntary. The accused would have to prove he was tricked or forced into drinking, was "reasonably mistaken" about what kind of drink it was or its likely effect, or was unaware that mixing alcohol with prescribed medication would produce a bad reaction.

Metropolitan Toronto Police are hoping this logo designed by one of their officers might become a widely-used symbol for campaigns against drinking drivers. This detail from a poster used during the Christmas season, was designed by Sergeant Don Colbourne of the community programs division and drawn by his daughter, Cynthia, an Ontario College of Art student.

Some smoke even after cancer surgery

CHELMSFORD, England — Smoking is so addictive even lung cancer surgery does not deter many patients from continuing the habit. In addition, doctors here say, many of these patients are not being given anti-smoking advice by their doctors.

Doctors at Broomfield Hospital said in a recent issue of *Thorax*, that of 52 patients who had survived five years after a lung cancer operation, 48% had resumed smoking though 56% had quit a few weeks before their operations.

Patients who had stopped smoking preoperatively were much less likely to return to smoking than those who quit after their operations.

Half of the patients had been told to stop smoking by a doctor. Of those given this advice preoperatively only 33% became smokers again, whereas 73% of those advised postoperatively returned to smoking.

Urine tests can help predict the most likely recidivists

By Mark Kearney

TORONTO — Urine testing of criminals at the time of arrest can help predict who will likely be re-arrested in the future, says a New York research scientist.

Eric Wish, PhD, of Narcotic and Drug Research Inc, says his six-year study shows those using drugs near the time of arrest are likely to be highly recidivistic and dangerous to the community.

"Hard-drug using arrestees tend to account for a disproportionate number of arrests for thefts and other property crimes, violate bail, and are likely to possess weapons," he said in a paper to the American Society of Criminology annual meeting here.

"They account for a high percentage of all arrests and, presumably, of total crimes committed, and tie up much of the resources of the criminal justice system."

In a United States study of 7,087 people arrested in the District of Columbia, 61% of those who tested positive for drugs had four or more arrests in the six-year period, compared to 23% of those who tested negative. The drug positives also had about twice as many arrests even when drug-related crimes were not included in the statistics, Dr Wish says.

Wish: the public is fed up

Currently, testing of arrestees is voluntary, but routine urinalysis could provide law enforcement officials, the courts, and treatment staff with valuable information for monitoring drug use and crime trends, and for dealing with drug abusers, he adds.

Dr Wish says the study also showed those who had been in a drug treatment program were more likely to have multiple arrests. These criminals were "treatment failures" who continued to take drugs during what was supposed to be detoxification, he says.

Dr Wish told **The Journal** this suggests that, when sentencing, judges should consider requiring the person to stay on treatment for a specific period of time, and that random urine surveillance take place to ensure no drugs are being used. Other studies have shown that drug users who are treated early and long enough reduce their criminal activity.

The study's findings could also lead to mandatory urine testing because "the public is fed up" knowing that drug users account for such a high percentage of crimes, Dr Wish says. However, in his paper, he cautioned any new policies may have to take into account that not all criminal drug users are recidivists.

BC hospital officials spurn role in BAL tests

By Eleanor LeBourdais

VANCOUVER — The British Columbia Health Association (BCHA) is concerned that an act to amend the Motor Vehicle Act with respect to blood testing for alcohol will interfere with the functioning of hospital emergency departments.

The act would empower police to demand a blood sample from anyone suspected of driving (or having care or control of a motor vehicle) and drinking within the preceding two hours. Under the act, the blood can be taken without consent if the individual is "incapable due to physical or mental trauma, of comprehending the nature of the demand."

Refusal to give a blood sample would be punishable by a fine of between $100 and $2,000, imprisonment for a week to six months, or both. The act would also make it a provincial offence to drive with a blood-alcohol level beyond 0.08%, which is already an offence under the Criminal Code of Canada.

The health association is concerned that if police bring an otherwise healthy person, suspected of being intoxicated, to an emergency department for a blood sample, the purposes and services of the emergency department may be overly compromised. The association feels it would detract from the primary duty of health care personnel — to care for the sick and the injured.

Such a situation could also cause serious disruption in an emergency department environment if hospital staff are attempting to obtain a blood sample from a possibly uncooperative, or belligerent, intoxicated individual, with other sick or injured people nearby.

The BCHA would prefer other wording in the act to enable police officers and/or police lab technologists to obtain the blood samples and arrange for their processing, as is the practice in Washington state.

The association also objects to provisions requiring hospital staff to be called away from patient-care duties to testify in court. Rather than asking professional witnesses to be on "standby" to the court for perhaps two or three days, the association believes they should be called in perhaps an hour before their testimony is needed.

Bill 69 [Motor Vehicle Amendment Act (No 2)] has passed third reading by the BC legislature but must still receive royal assent and be proclaimed by the cabinet before it becomes law.

GILBERT

'. . . lasting words about alcohol, some with echoes over the millennia . . .'

Boozewords: a brief history

By Richard Gilbert

The sensations of alcohol use are some of the threads of human experience. Prehistoric humans undoubtedly made alcoholic beverages, and in using them experienced much the same consequences as we do today. Mild and severe intoxication, and the after-effects of being drunk, have firm places in the inventory of human feelings. Only the taste and feel of alcoholic drinks can have changed. A Cro Magnon tippler enjoyed none of the mellow richness of fine sherry, the bitter-sweet blend of gin and good tonic, and the mixed tongue-tinglings caused by chilled vodka and ice.

Not surprisingly, some of our most primitive words describe these experiences and the substances that cause them. The words are primitive in that they are short, have held their meanings for centuries, and occur in similar forms in many languages.

Mead

According to Berton Roueché, writing in *Alcohol and Civilization* (S. P. Lucia, ed.), alcohol was discovered first as fermented fruit juice (wine), or as fermented grain (beer) or as fermented honey (mead), with the last being perhaps the most likely. Roueché's guess about the priority of mead was based on the occurence of "mead" (or something close to it) as a root word in both ancient Greek and Sanskrit with a range of meaning embracing sweet, intoxicating drink, drunkenness, and honey. Indeed "mead" means mead in an astonishing number of languages. As with "mother," which is also readily traceable back to both early Greek and Sanskrit, "mead" allows us to achieve glimmerings of verbal solidarity with our distant forebears.

But there is evidence of use of beer, wine, and mead far into prehistoric times, as much as 9,000 years ago, during the Neolithic Age. If we are trying to guess which alcoholic beverage came first, the verbal record must be a weak clue. Better might be the evidence of our ancestors' means of surviving. Until Neolithic times, humans were hunters and foragers, unlikely to come across quantities of fermented grain or fruit, but perhaps acquainted with the yield of sodden, abandoned beehives.

Mead is still produced and drunk today. Liquor stores in Ontario stock amphora-shaped bottles each containing 26 ounces of what is known in the trade as "medium mead" — 16% alcohol by volume and $4.20 the bottle.

Ale and beer

"Beer" goes back as far as the English language can be traced, but not much further. Until the 16th century, use of the word was mainly poetic, and rare. Thus an Anglo-Saxon translation of St Luke's gospel in the year 1,000 included the words "he . . . ne drincō win ne bēor" where now, in the King James version, we read "he . . . shall drink neither wine nor strong drink." But neither Geoffrey Chaucer nor William Langland, writing nearly four centuries later, used the word.

The English word for fermented grain was "ale," which also came from Anglo-Saxon. Ale was *the* alcoholic beverage in England even to the time of William Shakespeare, who early in the 17th century had one of his characters say that "a quart of ale is a dish fit for a king" (*The Winter's Tale*).

The word "beer" had just come into popular currency in Shakespeare's day. It was used to refer to the hopped beverage that had been introduced from Holland. Hops were added during fermentation of the barley malt to preserve the beverage (they killed many unwanted yeasts) and to improve its taste.

The use of beer was controversial in England for three reasons. One was that it came from abroad, and the English were, as now, unusually suspicious of strange things and strange habits. Another was the widespread but false belief that beer in its undiluted state was more intoxicating than the native ale, and, therefore, more hazardous to use. The third reason was that beer was often diluted, and the poorer, adulterated product could often not be readily distinguished from the real thing.

Shakespeare seems to have latched on to the last reason — dilution — because his references to beer were mostly references to "small beer." Thus he had Jack Cade, the rebel, say in a scene in *Henry VI*, "There shall be in England seven half-penny loaves sold for a penny . . . . . and I will make it a felony to drink small beer." The ideas excited the assembled crowd to such revolutionary fervor that Dick the butcher cried out, "The first thing we do, let's kill all the lawyers."

By the end of the 18th century all malt liquor was hopped. "Beer" and "ale" had become virtually synonymous, as they had been 800 years earlier. "Ale" when used today is mostly reserved for paler brews. Except in some parts of Britain, it has an archaic flavor.

Wine

The third of the prehistoric trio has an easy etymology. The word "wine" is readily traced to Latin. It serves as a conspicuous linguistic legacy of the Roman empire, appearing almost unaltered in Germanic, Slavic, and Celtic languages. Where the Romans got it from is unclear.

Romans, in common with other Mediterranean peoples of the time, mostly drank their wine diluted. One part wine to two parts water was the accepted ratio. The biblical reference to "strong drink" mentioned above was probably a reference to undiluted wine — about 12% alcohol by volume. The Anglo-Saxon translator may have been aware of the weakness of the usual Mediterranean beverage (about 4% alcohol), and used the stronger beer (5% to 7% alcohol) as a comparison.

Drinking undiluted wine was regarded by the ancient Greeks and Romans as a sign of barbarism. It is certainly a sign of foolishness, for 12% seems to be about the optimum concentration for engendering excessive alcohol use, whether as wine or as mixed drinks comprising distilled spirits diluted to about 12% by the addition of some kind of sweetened water (eg, tonic water or ginger ale).

Spirits

The highest concentration of alcohol that can be achieved through fermentation is about 17%. Stronger stuff comes only through distillation, invented by Arabs in the 9th century and spread as far as Scotland by the 15th.

Words for distilled spirits reflect their late arrival on the human scene. They are rarely monosyllabic, and exist in a wide variety of languages only because tourism and international trade have transported drinking practices. The *Oxford English Dictionary*, usually a redoubtable source of all kinds of information about the origins of words, seems unclear about "whisky" and almost defeated by "cocktail." Keller and McCormick's *Dictionary of Words about Alcohol* (Rutgers Center of Alcohol Studies, 1968) does better, noting 20 or so kinds of whisky or whiskey and rustling up a quote from Charles Dickens, who used "cocktail" in 1844.

The Rutgers dictionary scores over the Oxford regarding "booze" too. Both note that "booze" is a variant of "bouse" or "bowse," unchanged since Chaucer's time, meaning simply to drink to excess. Rutgers adds the nice point that the spelling may have been influenced by the Philadelphian distiller, E. G. Booz, who was well-known around 1840.

Each generation has discovered alcohol problems afresh, as the unchanging effects of altered neurochemistry interact with new cultures, new fads, and new technologies. The lasting words about alcohol, some with echoes over the millennia, serve to remind us of this drug's deep roots in human societies, and to warn us that little long-term change is likely in how alcohol is regarded.

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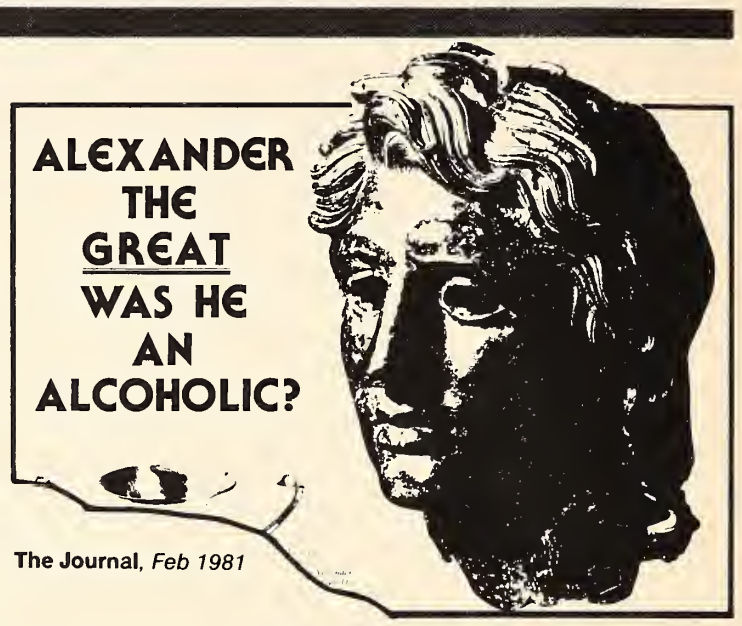
A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

FROM MARY RENAULT

Medicine, history disprove Alexander was alcoholic



The Journal, *Feb 1981*

Ed's note: One of Alexander the Great's most conscientious and celebrated biographers, Mary Renault, comments on an article, Alexander the Great: Was he an alcoholic, published in The Journal *in February, 1981. The article reported on work by John Maxwell O'Brien (PhD), an historian at Queens College, New York. Novelist-historian Renault, whose most recent novel is* Funeral Games, *which begins with Alexander's death, is also a former nurse.*

As I have said in my biography, *The Nature of Alexander*, much nonsense has been written about Alexander's drinking habits (**The Journal**, Feb 1981) which can be corrected by the most elementary medical knowledge, combined with the evidence of his life.

The matter comes under two heads, the medical and the historical. The theory of alcoholism does not stand up to examination under either.

The alcoholic is an addict, like any other drug addict, who needs the drug in his blood-stream all day. However the medical effects may fluctuate, he will be a permanently unfit man in the physical sense, incapable of sustained effort and endurance. Whatever one's estimate of Alexander's personality, it becomes irrelevant in the face of the material evidence. The history of Alexander produces, year after year, records by eye-witnesses of outstanding effort under harsh conditions, extended over days or weeks on end, during all of which he kept the reputation of sharing every hardship to which he exposed his men. Under campaign conditions, he had virtually no privacy; drunkenness and incapacity could not have been concealed, yet no single instance of it is recorded during periods of action.

No chronic alcoholic could stand up to ordeals like this. They continued up to the last year of his life, when in an arduous mountain campaign he subdued a rebel tribute which both his Persian predecessors and his Macedonian successors found ungovernable.

Episodes of heavy drinking by Alexander are always associated with social occasions. Festive drinking bouts were a male Macedonian tradition, dating from long before his reign; and it is unlikely that anyone left them sober. They were held to celebrate feast-days of the gods, victories, and so on. In his case, a competitive nature would ensure his drinking level, and his smaller size in a race of big men would give him, for the same amount taken, a higher concentration in the blood. It is clear from accounts of these incidents that the rest of the company was at least as drunk as he was.

During the last three years of his life Alexander sustained a massive, lacerated perforation of the lung in battle. Within a year he struggled, mostly on foot, through the appalling desert conditions of the Makran march, when his supply system from India broke down, and it was a long night's journey from one waterhole to another. Anyone who cares to read the account in full will realize that no alcoholic could have survived it.

When he died, he left no heir to suppress criticism of him, and for some time the succession was in doubt. Yet during these debates not a word against him was heard. He was deified; his body was treated as a sacred totem, and stolen (though with ceremonious dignity) to glorify the city of Alexandria. The prestige he was held to have conferred on the royal line led his grieving troops to the disastrous mistake of crowning his retarded half-brother, as his nearest kinsman. Degenerate alcoholics do not inspire, in men whom they have commanded, sentiments of this nature.

Mary Renault
Camps Bay
South Africa

COMMENT

Legal position dicey for DWI suspects

Last month, hundreds of thousands of motorists across Canada were stopped by the police in the annual holiday crackdown on drunk drivers.

After producing their licences and insurance certificates, the vast majority were permitted to go on their way. Many of those suspected of drinking, however, were asked by police to provide a sample of breath for analysis on a testing device either at the roadside or at the police station.

Canada's drinking and driving law puts such drivers in a precarious legal position. If a driver refuses, without lawful excuse, to provide a breath sample, he is guilty of a criminal offence (section 234.1 (2) or 235 (2) of the Criminal Code). If he complies, the test results can be used to prove he was driving with a blood/alcohol level in excess of 0.08% (contrary to section 236 of the Code).

The penalties are the same for all of these offences. Thus, a driver may refuse to cooperate and be convicted of one offence, or cooperate and provide evidence for his conviction for another.

In effect, the law compels the suspected drinking driver to provide police with evidence of his own guilt. This has not gone unnoticed by civil liberties groups, defence lawyers, and critics of the legislation. Indeed, the issue recently led Provincial Court Judge Maurice Charles to declare the mandatory breath-testing provisions unconstitutional. Later, in a similar case, the Ontario Court of Appeal chastised Judge Charles, saying these provisions did not offend either the Bill of Rights or the Charter of Rights and Freedoms.

Despite the publicity surrounding these cases, the legal principles remain a source of public confusion. This is unfortunate, for few cases have such a

(See — Comment — page 13)

The Journal

Calendar

1983

Hardley Jones

1877 MARCH 13 EARMUFFS PATENTED

1ST MARCH ST. DAVID'S DAY

1630 FEB 22 FIRST POPCORN EATEN BY PURITANS

1983

1626 MAY 6TH DUTCH BOUGHT MANHATTAN FOR $24 IN TRINKETS (WHOLESALE)

SEPT 26 1854 CHARGE OF THE LIGHT BRIGADE

MAY 2 YARDLEY JONES' CAT'S BIRTHDAY

AUG 11TH HAY FEVER SEASON BEGINS

JULY 15 ST SWITHIN RAIN TODAY MEANS 40 DAYS OF RAIN

NOV 22 ST. CECILIA. PRUNE GRAPEVINES NOW!

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1885 SEPT 20 JELLY ROLL BORN. NEW ORLEANS

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The Journal

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FOR YEARS NOW, NCA AN' THE BOYS HAVE BEEN GETTING TOGETHER FOR A FEW LAUGHS AN' A BEER...
NCA FORUM APRIL 14-17. HOUSTON TEXAS

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HOW LONG HAVE I GOT DOC?
30 DAYS NET
EXTRA BILLING
APRIL 24-27. TORONTO

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DENVER. COLORADO. NOV 9-12

CAF ANNUAL MEETING
MAY 2-4
MEDICINE HAT ALBERTA

5TH WORLD CONGRESS ON SMOKING
JULY 10-15 WINNIPEG. MANITOBA

JAN 17-21
SORRY NA'AH THAT'S KHAT K-H-A-T!
INTERNATIONAL CONFERENCE ON KHAT
ANTANANARIVO. MADAGASCAR

9TH INTERNATIONAL CONFERENCE ON ALCOHOL DRUG & TRAFFIC SAFETY NOV 13-18 SAN JUAN PUERTO RICO

ROYAL COLLEGE OF PHYSICIANS & SURGEONS
SCALPEL, SUTURES, SWAB, MINUTES, SPEECH, MOTIONS, COCKTAILS
SEPTEMBER 19-22 CALGARY

NAADAC CONFERENCE AUG 6-10 HOUSTON. TEXAS

HEADS IT'S A SUMMIT WITH REGAN — TAILS IT'S THE HIC! INTERNATIONAL INSTITUTE ON THE PREVENTION & TREATMENT OF ALCOHOLISM
JUNE 27-JULY 2 ZAGREB. YUGOSLAVIA

NOV 27-DEC 3
WHAT'S NEW ON THE HONG KONG DRUG SCENE?
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2ND PAN PAC / CONFERENCE ON DRUGS & ALCOHOL. HONG KONG

ALMACA OCT 1-7 MINNEAPOLIS. MINNESOTA

DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Ontario Psychiatric Association Annual Meeting — Jan 27-29, Toronto, Ontario. Information: Donna Gray, Assistant to the Program Chairman, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Teaching with Video Tapes — Jan 28, Montreal, Quebec. Information: Dr Yvonne Steinert, Kellogg Centre, Livingstone Hall, Montreal General Hospital, Cedar Ave, Montreal, PQ

Detox Training Programs (Non-Medical) — Feb 7-11, Apr 11-15, June 6-10, Toronto, Ontario. Information: Gord Gooding, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

36th Annual Convention of the Ontario Psychological Association — Feb 17-19, Toronto, Ontario. Information: Dr Carl Rubino, Convenor, OPA '83, 1407 Yonge St, Ste 402, Toronto, ON M4T 1Y7.

The Management of Employee Assistance Programs — Feb 23-25, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Recent Developments in Psychopharmacological Management — Mar 2, Montreal, Quebec. Information: Centre for CME, McGill University, 1110 Pine Ave W, Montreal, PQ H3A 1A3.

Health Research Ontario '83 — Mar 4 - Apr 4, Toronto, Ontario. Information: Sandra Tesolin, Public Relations Dept, Ontario Science Centre, 770 Don Mills Rd, Don Mills, ON M3C 1T3.

Drug Therapy — Mar 25-26, Regina, Saskatchewan. Information: CME Centre, University of Saskatchewan, 408 Ellis Hall, Saskatoon, SK S7W 0W0.

25th Annual Scientific Assembly of the College of Family Physicians of Canada — Apr 24-27, Toronto, Ontario. Information: George Ackehurst, Director of Communications, The College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

Clinical Criminology: Current Concepts Symposium — Apr 27-29, Toronto, Ontario. Information: Ms Evon Essue, Conference Secretary, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Drug Therapy — April 28-29, Montreal, Quebec. Information: CME, McGill University, 1110 Pine Ave W, Montreal, PQ H3A 1A3.

Theory and Practice of Group Psychotherapy and Counselling I — May 14-29, Toronto, Ontario. Information: Evelyn Piltch, 4 Finch Ave W, Ste 10, Willowdale, ON M2N 2G5.

Medic Canada '83 . . . Toward the Year 2000 — May 29-31, Edmonton, Alberta. Information: Toby Fay Sykes, Medic Canada '83, 480 Garyray Dr, Toronto, Ontario M9L 1P8.

5th World Conference on Smoking and Health — July 10-15, Winnipeg, Manitoba. Information: Kurt Baumgartner, Box 8159, Terminal PO, Ottawa, Ontario K1A 0C1.

2nd World Congress on Prison Health Care — Aug 28-31, Ottawa, Ontario. Information: Congress Secretariat, Medical Services Branch, The Correctional Service of Canada, Ottawa, ON K1A 0P9.

Royal College of Physicians and Surgeons Annual Meeting — Sept 19-22, Calgary, Alberta. Information: Robert A. Davis, Associate Director, Office of Fellowship Affairs, Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

United States

International Symposium on the Psychobiology of Alcoholism — Jan 16-18, Beverly Hills, California. Information: Health Sciences, UCLA Extension, PO Box 24901, Los Angeles, CA 90024.

Alcoholism — The Search for the Sources — Jan 19-21, Raleigh, North Carolina. Information: Sparky Carpenter, Information Specialist, PO Box 6507, Raleigh, NC 27628.

8th Annual Alcoholism Symposium: Intervention — The Key to Treatment and Recovery — Jan 19-21, Sacramento, California. Information: Gordon Stirling, Symposium Chairman, The Community Forum on Chemical Dependency Inc, PO Box 13871, Sacramento, CA 95813.

National Conference on Alcohol and Drug Abuse Programming in Colleges and Universities — Mar 1-3, Chicago, Illinois. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

American Society for Clinical Pharmacology and Therapeutics — Mar 9-11, San Diego, California. Information: E. H. Funk, Jr, MD, 1718 Gallager Rd, Norristown, Pennsylvania 19401.

National Alcoholism Forum, "Marketing the Message" — Apr 14-17, Houston, Texas. Information: Louisa Macpherson, Forum Coordinator, National Council on Alcoholism, 733-3rd Ave, Ste 1405, New York, New York 10017.

American Medical Society on Alcoholism — Apr 14-20, Houston, Texas. Information: J. Chen See, AMSA, 733-3rd Ave, New York, New York 10017.

National Association of Alcoholism Treatment Programs (NAATP) — May 13-16, Kansas City, Kansas. Information: Mrs Kim Farthing, NAATP, 1300 Bristol St, North Newport Beach, California 92660.

Scholarly Communication Around The World — The 27th Annual Conference of the Council of Biology Editors, The 3rd International Conference of Scientific Editors and The 5th Annual Meeting of the Society for Scholarly Publishing — May 15-20, Philadelphia, Pennsylvania. Information: 1983 International Conference, Attn: Elizabeth M. Zipf, BioSciences Information Service, 2100 Arch St, Philadelphia, PA 19103.

2nd Annual Conference on Alcoholism and the Family — May 25-29, Philadelphia, Pennsylvania. Information: Richard W. Esterly, Chairman, National Conference on Alcoholism and the Family, Box 277, Wernersville, PA 19565.

World Congress on Mental Health — July 22-28, Washington, DC. Information: World Federation for Mental Health, #107-2352 Health Sciences Mall, University of British Columbia, Vancouver, British Columbia V6T 1W5.

National Association of Alcoholism and Drug Abuse Counsellors (NAADAC) — Aug 6-10, Houston, Texas. Information: National Association of Alcoholism and Drug Abuse Counsellors, 951 S George Mason Dr, Arlington, Virginia 22204.

7th Annual Summer Institute of Drug Dependence — Aug 14-19, Colorado Springs, Colorado. Information: Dan Bartmettler, Director, The Institute for Integral Development, PO Box 2172, Colorado Springs, CO 80901.

Alcohol and Drug Problems Association of North America 34th Annual Meeting — Aug 28-Sept 1, Washington, DC. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

American College of Chest Physicians — Oct 23-27, Chicago, Illinois. Information: Exec Dir A. Soffer, MD, FCCP, 911 Busse Hwy, Park Ridge, IL 60068.

American Association for the Study of Liver Diseases — Nov 4-7, Chicago, Illinois. Information: C. B. Slack, 6900 Gorve Rd, Thorofare, New Jersey 08086.

American Society of Criminology 35th Annual Meeting — Nov 9-12, Denver, Colorado. Information: Joseph E. Scott, Dept of Sociology, Ohio State University, Columbus, Ohio 43210.

1983 Western Regional Conference — Nov 13-16, Los Angeles, California. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

Abroad

International Conference on KHAT — The Health and Socio-Economic Aspects of KHAT Use — Jan 17-21, Antananarivo, Madagascar. Information: Archer Tongue, Director, International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

NSAD 10th Biennial Summer School on Alcohol, Drugs and Chemical Dependency — Jan 26-28, Wellington, New Zealand. Information: Bursar, Barbara Mills, NSAD, PO Box 1642, Wellington, New Zealand.

World Conference on Alcoholism — Feb 26-Mar 6, London, England. Information: Pat Fields, Charter Medical Corp, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, Georgia 30342.

Pharmacological Treatments for Alcoholism: Looking to the Future — Mar 28-31, London, England. Information: Ms Nina Little, Alcohol Education Centre, The Maudsley Hospital, 99 Denmark Hill, London SE5 8AZ England.

World Symposium on Acupuncture — May 26-29 Bombay, India. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

29th International Institute on the Prevention and Treatment of Alcoholism — June 27-July 2, Zagreb, Yugoslavia. Information: Archer Tongue, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

7th World Congress of Psychiatry — July 11-16, Vienna, Austria. Information: Congress Team International, PO Box 9, A-1095 Vienna, Austria.

Australian Medical Society on Alcohol and Drug Related Problems 3rd Annual Conference — July 31-Aug 7, Cairns, North Queensland, Australia. Information: Conference Organizers, PO Box 155, Civic Square, ACT, 2608, Australia.

Middle Eastern Summer Institute on Drug Use (MESIDU): Techniques, Strategies, Concepts, Options — September, Jerusalem, Israel. Information: Stan Einstein, PhD, Director, MESIDU, 113/41 East Talpiot, Jerusalem, Israel.

International Conference on Alcoholism — Sept 26-30, Reykjavik, Iceland. Information: International Council on Alcohol and Addictions, Case postale 140, 1001 Lausanne, Switzerland.

13th International Institute on the Prevention and Treatment of Drug Dependence — Oct 10-14, Oslo, Norway. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

9th International Conference on Alcohol, Drugs, and Traffic Safety — Nov 13-18, San Juan, Puerto Rico. Information: T-83 Secretariat, GPO Box 5067, Medical Sciences Campus, San Juan, Puerto Rico 00936.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

2nd International Congress on Drugs and Alcohol — Dec 18-22, Tel Aviv, Israel. Information: Congress Secretariat: Peltours Ltd, Congress department, PO Box 394, Tel Aviv, 61003 Israel.

Benzodiazepines

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Benzodiazepines

Today

"Valium addiction" is one of today's fashionable illnesses. It is also in vogue as a media subject, discussed in myriad articles, television programs, books, and films. Yet, many studies show that the incidence of benzodiazepine dependence is very low; that many patients find it easier to admit to the "addiction" than to the emotional disorders that precipitated their first use of the drug; and that a large percentage of those who are dependent also have a high alcohol intake. A major California study found few "pure" benzodiazepine patients.

At the same time, many clinicians realize that some patients who take only therapeutically-recommended doses of the drugs do become dependent over a long period of time and need help to stop taking them.

And their use in the treatment of alcoholism is fraught with questions and disagreements. They both help and harm.

These are some of the issues covered in this second of two major reports by Harvey McConnell (The Journal, Dec 1982) on The Benzodiazepines Today — a look at two decades of research and clinical experience, a recent, two-day conference in San Francisco.

McConnell

The inordinate publicity given to the miniscule number of benzodiazepine misusers has caused concern that many individuals are impaired by, dependent upon, and prone to withdrawal reactions from these drugs," says Frank Ayd, a clinical professor of psychiatry.

However, although psychological and physical dependence on the drugs may occur, "the incidence is very low and is not a cause for undue alarm," Dr Ayd, of West Virginia University Medical Centre, said.

(In Dr Ayd's absence, David Smith, medical director, Haight-Ashbury Free Medical Clinic, San Francisco, read his paper.)

Dr Ayd said the drugs are used extensively because of their efficacy as anxiolytics, hypnotics, muscle relaxants, and anticonvulsants, plus their high level of safety in comparison with other prescription drugs. They are rarely fatal in either accidential or deliberate overdoses.

On the other hand, he said, even at therapeutic doses the benzodiazepines may produce some degree of psychomotor and cognitive impairment.

Workers

The pharmacokinetics of the benzodiazepines are such that impairment of psychomotor and cognitive functions is most pronounced within 20 to 30 minutes after they are taken orally and then declines rapidly as plasma levels of the drug peak and recede.

Workers in industry should be advised to avoid hazardous situations within an hour after taking a benzodiazepine. Possible danger can be minimized even more by a bedtime dose of a long-acting benzodiazepine which rarely has a hang-over effect, but which has a carry-over effect which can improve performance by reducing anxiety-induced impairment.

Every doctor should warn every patient "that even relatively small amounts of alcohol with therapeutic doses of the benzodiazepines can significantly impair information processing and work performance," he cautioned.

Dr Ayd said misuse and dependence happens often among alcoholics and drug-dependent individuals "but the allegation that benzodiazepine dependence occurs most often in the so-called 'addiction prone' is questionable."

Tolerance

Age, sex, and the presence or absence of psychiatric problems appear to have no bearing on the development of tolerance or withdrawal symptoms.

Dependence and withdrawal are a consequence of both daily dosage and time.

Dr Ayd noted that if no cross-tolerant drug, such as barbiturates, meprobamate, or alcohol, is taken before therapeutic doses of benzodiazepines, and use is for less than 29 weeks, there is little risk of a withdrawal symptom. But, if a cross-tolerant drug is taken weeks before benzodiazepine use commences, and if therapeutic doses of benzodiazepines are taken for four to six months, there is a risk of mild, transient withdrawal symptoms.

However, withdrawal of therapeutic doses taken for years may produce moderate-to-severe, and protracted symptoms.

Acute withdrawal begins within one to nine days after benzodiazepines are stopped. There is marked anxiety, increased tremor and shakiness, weight loss, and patients have complained of such things as tinnitus (ringing in the ears), blurred vision, palpitations, vertigo, and swaying while standing or walking. Perceptual changes, such as photophobia and a feeling of perpetual motion, can be marked.

Seizures

Patients suffering from acute withdrawal crave the drugs, and may become agitated, aggressive, irritable, and uncooperative. Seizures may proceed or follow periods of insomnia, or there may be a rapid emergence of psychosis or delirium.

With appropriate treatment, recovery from acute withdrawal symptoms is complete and prompt.

Dr Ayd said chronic symptoms begin between the ninth and 20th day after abrupt withdrawal, and are seen generally in long-term, high-dose users, and in those dependent after long-term therapeutic dosages.

Chronic withdrawal can be protracted and symptoms generally include depression, agitation, insomnia, severe nightmares, loss of appetite, and an aggravation of pre-existing psychological distress. This may last from 15 to 45 days.

Dr Ayd said although the incidence is low, there are patients who suffer from chronic benzodiazepine intoxication. They are often smart enough to conceal this when examined by a doctor by not taking the drug for several hours before examination.

Some patients can take up to 200 mg a day, or more, and not manifest symptoms when examined. Chronic benzodiazepine intoxication may cause confusion, cognitive impairment, emotional instability, apathy, accentuation of pathological personality traits, and even anorexia. Such users are also impaired while driving.

With appropriate treatment, chronic users who become intoxicated can be effectively treated.

As for treatment, Dr Ayd said many patients cannot stop taking benzodiazepines on their own. "Each time they try, they experience distressing abstinence symptoms which spur them to resume taking the drug for relief."

Government

The doctor should decide which patients should be treated in hospital and which on an outpatient basis. Those who have a low tolerance for discomfort may seek relief through sedatives or alcohol, and should be treated in hospital.

Low-dose benzodiazepine users can be weaned gradually as outpatients, and many of these patients do so on their own.

Dr Ayd said that if his fellow doctors rationally prescribe the benzodiazepines and help patients understand the nature of the drugs, there is less likelihood of any effort by government to restrict their prescribing.

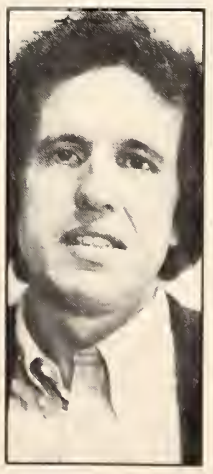
Addressing the question of overprescribing, Dr Smith said those who work in the field of chemical dependence have been consistently pointing out — yet it has been hard for many to understand — that "people react differently to drugs."

"Overprescribing suggests that everybody reacts to a particular drug in the same way. Therefore, if you give too much, that is overprescribing. The fact is that the evidence shows quite the opposite: people react differently to drugs, and what may be appropriate prescribing to a majority of the population may be inappropriate prescribing to a minority of the population that has a psycho-biological predisposition to addiction."

Doctors are not educated about addictive diseases and do not understand the concept of addiction, Dr Smith said. "They tend to prescribe psychoactive drugs as though we had a uniform population and all reacted the same."

Dr Smith said that long term research at the Haight-Ashbury Free Medical Clinic, San Francisco, has led workers there to conclude that few people who believe themselves benzodiazepine-dependent use only benzodiazepines. The research showed more than 70% had a history of alcohol abuse and chronically took anti-depressants, neuroleptics, or other sedative hypnotics as well.

Ayd



Smith

It has been their experience that patients who develop withdrawal symptoms have taken many times the therapeutic dose of benzodiazepines, and combined them with alcohol and other drugs. At the same time, there is no question that the low-dose benzodiazepine syndrome does exist.

Doctors

Dr Smith said he and his colleagues believe it is essential doctors who prescribe benzodiazepines for a long period of time take a family history of the patient and determine whether there has been a history of alcohol abuse by the patient or by members of his family.

Dr Smith said it is also vital for doctors to distinguish between symptom generation as a result of benzodiazepine use, and symptom suppression and symptom reemergence following discontinuation of the drug. This can be difficult, but the distinctions must be made.

He explained: "In symptom reemergence, the patient's symptoms of anxiety, insomnia, and muscle tension have been masked during the period of benzodiazepine treatment, and the individual has forgotten the initial severity. Discomfort in the present seems more real than that experienced in the distant past, and present discomfort may be believed to be more severe, when, in fact, it is of equal severity to that before treatment.

"In symptom supression, if the patient's initial symptoms were secondary to a progressive process, symptom progression may have been masked during benzodiazepine therapy. When the benzodiazpine is stopped, symptoms emerging are, in fact, more severe in intensity than (they were) prior to taking the benzodiazepine.

"The etiology of the symptom intensification is due to progression of disease rather than benzodiazepine withdrawal."

The low-dose dependence syndrome will have a cyclical, but gradually declining, course; one day may be better than the next, and anxiety and insomnia will come and go before fading.

Distinctions

"But symptom reemergence will not go away with time," Dr Smith said. The benzodiazepine has acted as a symptom supressor and, when it is removed, the symptom will return and it may have changed in character.

In patients given benzodiazepines for a long time, and then deprived of them, symptoms for the underlying emotional disorder return and have progressed.

A failure to make the distinctions is bad medicine, Dr Smith believes. "If you have told a patient this will go away with time, he has been given an incorrect message, because it will not go away with time. In fact, it may get worse with time."

Dr Smith said research has suggested that some high doses of benzodiazepines can suppress the symptoms of schizophrenia.

Dr Smith: "Books and articles have been written which, in fact, (are describing) classic cases of symptom reemergence, yet everything that happens is blamed on Valium by the authors."

Dr Smith said a quixotic finding in the substance abuse field is the complicated interaction between methadone maintenance and diazepam. There are several

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In symptom progression, symptoms may have been masked during benzodiazepine therapy and have grown more severe by the time therapy is stopped . . .

People want to view themselves as 'Valium dependent' rather than neurotic or emotionally disturbed . . .

(from page 11)

theories as to why people on methadone maintenance, who are opiate-oriented, will take diazepam.

One is that people on methadone maintenance are addicts and will use anything available. Another is that a large number of people on methadone maintenance are alcoholics.

Dr Smith and colleagues have found some validity in both theories, but they have also found other reasons to explain the association.

"One of the reasons they do this is that diazepam and methadone somehow enhance the euphoria associated with methadone. But we have found also with many addicts that when their methadone dose gets too low, their underlying psychopathology reemerges and they start to self-administer diazepam," Dr Smith added.

Neurotic

Donald Wesson, psychiatrist, member of the California Board of Medical Quality Assurance, and consultant to the Peralta Alcoholism Facility, Berkeley, has collaborated with Dr Smith on long term study of the benzodiazepines.

He said while they are sure low-dose benzodiazepine dependence does exist, they have looked long and hard for cases of "pure" benzodiazepine dependence.

"Even though patients come in and say 'I am Valium dependent,' the fact is that only in a few cases have we found patients who took only benzodiazepines. They are either concomitantly using alcohol, or, more commonly, they are using prescribed medication, not infrequently other sedative hypnotics."

One reason for patients claiming they are "Valium dependent" is that it is now a fashionable complaint. "People want to view themselves as Valium dependent rather than neurotic or emotionally disturbed."

Dr Wesson said that in treating patients with low-dose benzodiazepine withdrawal they use propranolol, a beta blocker, 20 mg every six hours, starting on the fifth day of detoxification. It is discontinued after two weeks.

Dr Wesson cautioned that propranolol can have a rebound effect when stopped abruptly. After the initial therapy they use propranolol in "bursts" to control the emergence of hyperactivity.

"In our hands, propranolol works well and there have been no major complications."

Dr Wesson said that, at least on the West Coast, too many psychiatrists are unaware of the low-dose benzodiazepine dependence/withdrawal syndrome. "Many think addiction is only in high doses." Patients with low-dose dependence are told: "Well, if you want to get off, then get off," and no assistance is offered.

Another area of benzodiazepine use — and misuse — still not generally understood by the medical community is the link between alcoholics and the drugs. While benzodiazepines can be useful in the initial detoxification of an alcoholic, continued use when the alcoholic is trying to recover can, paradoxically, cause relapse.

Alcoholics

John Newsom, medical director of the care unit, South Coast Medical Center, South Laguna, Cal, said: "Benzodiazepines used by alcoholics is an addiction in itself. You can have a severe, prolonged withdrawal syndrome, and I think there is an increased risk of a seizure.

"I think the continued benzodiazepine use by recovering alcoholics predisposes them to relapse, and this is not generally acknowledged in the general, medical community. I feel my colleagues are not really paying enough attention, and harm is being done to alcoholics."

Dr Newsom says he has had a number of cases where the patient has gone to the doctor while recovering from alcohol or drug problems. Many doctors insist on prescribing benzodiazepines and get very angry if the patient protests that he or she should not be taking such medication.

"As soon as they prescribe benzodiazepines, this tips the patient over and they will return to drinking."

Sleep

Dr Newsom said a major problem today is that almost every alcoholic under the age of 35 years is a polydrug abuser. "We see very few pure alcoholics any more in the lower age group."

In their withdrawal program with alcoholics, Dr Newsom's unit use diazepam 10 mg to 20 mg orally every hour and flurazepan HCl (Dalmane) for sleep the first four nights "as we think a good night's sleep, particularly on the first night, is important."

Benzodiazepines can have a paradoxical effect: some patients under the normal detoxification regimen suddenly become more and more agitated. If the dosage is increased "they are flying around the room. You are dealing then with the paradoxical effect, and it is probably best then to switch to phenobarbitol."

Dr Newsom said clinicians are left in a dilemma: "The benzodiazepines are a useful medication when they are used to relieve withdrawal symptoms in a hospital environment, but they are harmful, as well, when used for outpatient alcoholics, whether they are recovering or not.

Negligent

"I am convinced from our research and review of the literature that the routine prescription for alcoholics, whether practising or recovering from the disease, are not only unethical, but criminally negligent."

Dr Smith said in many programs the alcoholic is undermedicated during detoxification and overmedicated during the after-care, recovery period.

"It has been our clinical experience, and something clinicians should be aware of, that although the alcoholics over the long term would like benzodiazepines to be prescribed because they will report symptom relief, the drug increases the probability that they will relapse back to their primary disease of alcoholism. And alcoholism is a chronic, relapsing, potentially fatal illness."

Benzodiazepines

Benzodiazepines

Benzodiazepines

Feuer: Flight attendants have special problems

EAPs in place for US high fliers but pinning down treatment is hard

By Harvey McConnell

PHILADELPHIA — One question guaranteed to make airline officials blanch is: how many pilots and flight attendants have alcohol problems?

Safety — and a wish to allay fears of passengers — is the reason.

It's also the reason the United States Airline Pilots Association and the Association of Flight Attendants have employee assistance programs (EAPs), says Barbara Feuer, director of the program for the 23,000 members of the Association of Flight Attendants.

Ms Feuer, who attended the annual conference of the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) here, said association members work for 16 US airlines. Their EAP is financed by the union, not the companies.

She said: "Many of the problems among flight attendants are the same as those in the general population. But there are some major differences, both in the kind of life they lead, and the ways we try to provide help."

Of the attendants, 87% are women, the average age is the middle 30s, and the average length of flying is 10 years. Ms Feuer said they are "an intelligent, well-educated group" and belie "a lot of the stereotypes people have about flight attendants."

Pressure starts from the time they report for duty, Ms Feuer said. While many people can do their work in silence when they have a "bad day," flight attendants "have to relate to the public and try to meet their demands, whatever they may be."

There are the particular physiological stresses of flying long distance — "the idea that you may get into a strange city at 2 am on a layover, or you may fly a charter for two weeks and you are away from home."

Ms Feuer said for many flight attendants it is also "a challenge to make a relationship work."

The program is based on peer-referral and not on the traditional supervisor-employee model.

Ms Feuer: "We have about 100 trained EAP representatives among the 16 carriers. This is all voluntary work on their part. Some are recovering alcoholics, but many are not.

"They try to educate members about the program, we have a newsletter and general meetings, and our (telephone) numbers and those of the EAP representatives are published. Thus flight attendants out there know they have someone they can contact if they have problems, or if they think that a co-worker has problems."

The program relies on peer pressure. Ms Feuer said colleagues are "worried that this person is going to get worse without help and they are scared because they know how things need to be on a flight."

An added problem for flight attendants is that alcohol is always available on the plane — and passengers demand it.

Ms Feuer said although some airlines experimented with not serving drinks on flights until the afternoon, they had to change that policy because many passengers got angry.

Confidentiality is essential and names of attendants in the program are never disclosed without their permission. Some companies need to know in terms of giving the attendant time off, but others don't insist on it.

Ms Feuer said when an attendant with problems finally contacts an EAP representative "we then have a challenge to try and find a treatment facility. That is not easy as they are always flying about the country."

As far as possible, the EAP representative tries to link the attendant to a program in his or her own home community.

When the attendants are on duty, the association has established links with AA and other groups all over the world "so if somebody lands up in Saudi Arabia, for example, where alcohol is forbidden, there is an AA group they can attend."

Kiwi slogans

AUCKLAND, NZ — "Drink little, live a lot" has won a slogan competition organized among New Zealand schools by the Alcoholic Liquor Advisory Council. Second was "Boozy drinking, woozy thinking" and third was "Kiwis do it better sober." Among those highly commended were "The bubbles tickle your nose but your liver's not laughing" and "Alcohol — the worst athletic support on the market."

Drawing is one therapeutic technique used to help children of alcoholics express feelings that may be too painful to discuss. This poster, submitted by the County of Nassau, Department of Drug and Alcohol Addiction, Hempstead, New York, was part of a display titled: "Through the Eyes of a Child: Parental Alcoholism" at the Governor's Conference on Children of Alcoholics in New York.

Alcoholics' adult offspring share many characteristics

By Lynn Payer

NEW YORK — Psychotherapists treating adult children of alcoholics must have some understanding of alcoholism, says Judith Seixas, a consultant to the Boston Center for Alcohol and Health.

Children of alcoholics tend to share certain characteristics, she said, and if the therapist isn't aware of this, therapy may be very unproductive.

On the other hand, she said, the problems of children of alcoholic parents are often more treatable because they are more traceable.

"I myself, who am not the child of an alcoholic, have trouble finishing tasks. But, when you mention this to children of alcoholics, their response is: "But, did anybody ever finish anything?"

Speaking here to the Governor's Conference on Children of Alcoholics, Ms Seixas said people in her therapy group for adult female children of alcoholics were surprised by how much they had in common.

Holidays: "The first question was 'What am I going to do for Thanksgiving? Mom's going to be drunk."

Trust: "Since nothing happened the way it was planned, since parents made promises that didn't happen, there is always the question in the workplace, in relationships, on the street: 'Can I believe what you're telling me?'"

Parent's drinking: "What is my role? Am I supposed to hide bottles?"

Confusion between love and money: "One alcoholic father would, every time something went wrong, give his daughter some money. Now, at 35, she cannot understand why anyone would really like her unless she paid them for their love."

Having children: "'There's alcoholism all over my family; should I have children?' That's an issue we've discussed a lot."

Rescue fantasies: "This starts early, when the child thinks, 'if I'm good, things will change.' The fantasy is often reinforced by a parent. 'If you'd taken out the garbage, I wouldn't be drinking this way.'"

Smell of alcohol on someone's breath: Adult children of alcoholics may over-react if a spouse comes home with alcohol on his breath after drinking socially. "To her, that smell means trouble. It's not at all a cerebral thing."

Leaving home: "A lot of these people left home when they were very young and not ready to leave."

Ms Seixas said her group members went to Al-Anon as well as therapy but there were two problems with Al-Anon: It is difficult to have groups limited to the children of alcoholics because of the nonexclusionary nature of Al-Anon, and no professionals are present to help take care of severe problems when they arise.

Seixas: traceable, treatable

Group urges breathtesting

TORONTO — A committee of the Canadian Society of Forensic Sciences recommends that breath analysis tests continue in Canada despite concerns about unreliable breath sample readings.

The concerns were raised about the test's reliability after the manufacturer, Smith and Wesson Inc of Springfield, Mass, issued warnings that the breathtesting machine's readings can be affected by nearby radio transmission broadcast interference.

Douglas Lucas, head of the society's committee, said operating conditions for the analysis device in Canada are much more stringently controlled than those in the United States. However, since the company's warning, some impaired-driving court cases in British Columbia have been adjourned because of the test's possible unreliability.

COMMENT Continued

(from page 6)

widespread impact. Had Judge Charles' decision been approved, the roughly 150,000 drinking-driving charges laid annually would have dwindled to a trickle, and law enforcement programs in this field would have had to have been dismantled.

Judge Charles' 72-page judgement raises several constitutional issues. The most important is the accused's protection from self-incrimination — a right specifically guaranteed in the Bill of Rights and alluded to in the Charter of Rights and Freedoms.

The Bill of Rights, enacted in 1960, continues in force alongside the Charter. Section 2 (d) of the Bill says no federal law shall be construed and applied so as to deny a person protection against self-incrimination.

In 1972, the Supreme Court of Canada clearly stated that compulsory breathtesting legislation did not violate this right. The court defined the self-incrimination provision narrowly, indicating that it only protected an individual from having his testimony in court used against him in subsequent criminal proceedings. In the court's view, breathtesting, fingerprints, hair samples, and similar evidence raised no issue of self-incrimination.

The Charter of Rights and Freedoms does not use the term self-incrimination, but rather confers two limited rights of a related nature. First, a person charged with an offence cannot be forced to be a witness. Secondly, a witness has the right not to have the evidence he gives in one proceeding used to incriminate him in any other proceeding, except in perjury prosecutions. In the words of the Ontario Court of Appeal, "it is plain that the protection continues to be protection against testimonial compulsion and nothing else."

In summary, the higher courts have clearly held that the compulsory breathtesting provisions do not violate either the Canadian Bill of Rights or Charter of Rights and Freedoms. If these self-incrimination cases are any indication, drinking drivers cannot expect to rely on the Bill or Charter to shelter them from the rigors of Canada's drinking and driving legislation.

Susan Sapin, James Le Ber, Lawrence Blokker, and Paul Gemmink
Law students
University of Western Ontario
London

NEWS AND DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact the group, at (416) 595-6150.

Mr Finley's Pharmacy

Number: 529.
Subject heading: Over the-counter-drugs, prescription drugs.
Details: 12 min, 16 mm, color, 3/4" video.
Synopsis: A young girl puppet has been assigned to find out about drug use for the school newspaper. She decides to interview her local pharmacist, Mr Finley. While she is conducting the interview several people come in to get prescriptions filled and Mr Finley gives his advice on how to handle drugs properly and wisely.
General Evaluation: Good to very good (4.7). This well-produced film was judged to be a good teaching aid that could lead to good decision-making regarding the use of prescription and over-the-counter drugs. General broadcast was recommended.

Recommended use: Of benefit to audiences ages 8 to 15 years.

Who Loves Amy Tonight

Number: 530.
Subject heading: Attitudes and values, communication, drugs and youth.
Details: 28 min, 16 mm, color.
Synopsis: Amy, a teenager involved in shoplifting, and breaking and entering, refuses to tell her parents what she is doing at nights, where she is going, and whom she is seeing. Time after time she lies her way out of situations and threatens suicide when her father attempts to discipline her. Finally her father reaches the end of his rope. He follows Amy when she makes a narcotic drop and photographs her. This time when she threatens to kill herself he does not step in. Amy realizes her father means what he is saying and she must change.
General evaluation: Good (4.3). This contemporary, well-produced film had high emotional impact, and could provide the basis of good discussion about how to handle teenage children.

Recommended use: With the presence of a resource person, this film would especially benefit parents.

The Final Ingredient

Number: 533.
Subject heading: Drugs: pharmacology, drug use; etiology and epidemiology, prescription drugs.
Details: 14 min, 16 mm, color.

Synopsis: There are many kinds of medicines produced today for all sorts of illnesses and problems. However, it is important to use these drugs wisely. The manufacturers carefully prepare and test their products. The doctor prescribes for specific symptoms and personal characteristics. The pharmacist carefully prepares the quantity and ingredients necessary. However, the "final ingredient" is the patient. It is up to each individual to follow directions properly, not mix drugs inappropriately, and not be careless about drugs.

General Evaluation: Fair to good (3.8). This contemporary, well-produced film was judged to have a clear message even though the group felt it took a long time to say it.

Recommended use: Of benefit to all adult audiences.

Minors may be counselled without parental consent

NEW YORK — Minors with problems of alcohol abuse may now be treated in New York State without parental consent, and children of alcoholic parents may be "counselled" without their parents' knowledge.

Karen K. Peters, counsel to the Division of Alcoholism and Alcohol Abuse in Albany, NY, told the Governor's Conference on Children of Alcoholics a law was passed by the New York State legislature in June. It permits treatment of alcoholic minors voluntarily seeking treatment if a physician determines the minor needs treatment and believes obtaining parental consent would be detrimental.

The "preventive counselling" of children of alcoholics without parental consent is now possible, not because of a statute but because of guidelines promulgated by the state, she said.

"Some of you will say 'that's not preventive counselling services, that's treatment.' Trust me. From a lawyer's point of view, you are providing services to that child to prevent him from becoming an alcoholic . . . When we talk about preventive counselling we're talking about talking, rather than touching. No prescription of drugs, just talking," said Ms Peters.

She said the law necessary for the actual treatment of alcoholic minors had taken four years to pass. She hopes it will not mean parental consent will never be sought.

Ms Peters: "The law was not written so every single child should get treated without parental consent in every single situation. That is not the approach, because alcoholism is a family disease. The intent of the statute, and it's very clear, is that if you do start treating the child without parental consent, make an effort to get the parents involved."

Under the statute minors can be treated even if their parents deny consent, or withdraw consent they originally gave, as long as the physician determines the child needs treatment.

Peters: talking not touching

The law applies to detoxification units if they are certified separate detoxification units. "If the detox bed is a scatter-bed in a general hospital, then the hospital's not going to admit that child," Ms Peters said.

Steven Schwartz, director of the Stutzman Alcoholism Treatment Center in Buffalo, NY, said parents cannot be billed for service to their child if they have not consented to treatment.

However, he said, "these laws were made to allow us to do treatment of children where we thought we were restricted in the past.

"Nobody ever said 'I want to be able to treat children and get paid for it.' They said: 'I want to be able to treat children.' "

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Milk on tap at UK pub

MANCHESTER — An English pub has something new on tap — draught milk. At the Shakespeare Pub here, the traditional English pint of beer is under attack. Milk is now being offered for customers concerned about their health. The pub owner says milk is a good lining for the stomach.

This publication is indexed in

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New Books by RON HALL

Drinking and Problem Drinking

. . . edited by Martin A. Plant

This book provides a concise, objective and up-to-date review of new research and current thinking on the subject, based in part on fieldwork findings. Many of the topics discussed are controversial, and are likely to remain so for some time, particularly teenage drinking, control policies, controlled drinking, and the fetal alcohol syndrome. The book is an attempt to examine the tragedies of alcohol misuse in relation to general drinking habits, and to relate to both the general issues of how and why alcohol is so popular and what responses are feasible and appropriate either to help the casualties of excessive drinking or to prevent and minimize further harm. The historical development of, and definitions of 'alcoholism' and 'alcohol problems' are described. The 'disease concept' is reviewed together with the clinical and social features of alcohol-related harm. The literature on the causes of alcohol problems is reviewed, and an overview of drinking habits and patterns of alcohol problems is presented.

(Junction Books, 15 St. John's Hill, London SW11, England. 226 p. £ 5.95 ISBN 0-86245-063-2)

Alcoholism and Aging: Advances in Research

. . . edited by W. Gibson Wood and Merrill F. Elias

The objective of this book is to present some of the research on alcohol and aging, to discuss directions for future studies, and to discuss theoretical and methodological issues related to alcohol research with the aged. There are four sections, each followed by a commentary on the chapters and a general discussion of the section topic. The four sections are: drinking patterns, symptomatology, and clinical intervention; neuropsychological and neurological consequences of alcohol and aging; animal models for the effects of alcohol on aging organisms; and theoretical and methodological issues associated with gerontological research. Topics range from epidemiology to the biochemical effects of alcohol across the life span. The book is intended for researchers and clinicians working in areas of alcohol and/or aging and to be used as a reference source for additional information.

(CRC Press, 2000 NW 24th Street, Boca Raton, FL 33431, 1982. 240 p. $74.00 ISBN 0-8493-5832-9)

Other Books

Brain Neurotransmitters and Hormones — Collu, Robert; Ducharme, Jacques R.; Barbeau, Andre; and Tollis, George (eds). Raven Press, New York, 1982. Non-striatal dopaminergic systems; GABA and benzodiazepines; brain peptides; psychoneuroendocrinology, rhythms, and stress; neuroendocrinology of ethanol. Index 409p. $57.84.

Drug Abuse In East Asia — Spencer, C.P., and Navaratnam, V. Oxford University Press, New York, 1981. History of drug production and use; contemporary patterns of abuse; adult and adolescent drug users; preventive education and information campaigns; treatment and rehabilitation; legal and enforcement responses to drug abuse; society's response to drug abuse. Bibliography, index. 227p. $42.60.

Perspectives In Alcohol and Drug Abuse: Similarities And Differences — Soloman, Joel, and Keeley, Kim A. (eds). John Wright/PSG, Littleton, 1982. Historical review; sociocultural aspects; pharmacology; personality and psychopathology; combined alcohol-drug abuse and human behavior; combined treatment; prevention; research relating to alcohol and opiate dependence; law; political aspects. Index. 259p.

Drug Use In Pregnancy — Niebyl, Jennifer R. (ed). Lea and Febiger, Philadelphia, 1982. Treatment of nausea and vomiting; use of mild analgesics; antibiotics; anti-asthmatic drug use; anticoagulants; corticosteroids in the prevention of respiratory distress syndrome; smoking and pregnancy; risk of alcohol; narcotic addiction; caffeine in pregnancy. Index. 194p. $26.52.

More than 100 drugs discussed

Guide outlines drug facts, issues

By Mark Kearney

TORONTO — Help is on the way for officials of the justice system who must deal with the often-confusing world of drug abuse.

Drugs and Drug Abuse: A Reference Text, published by Ontario's Addiction Research Foundation (ARF), now available, is designed as a guide to the issues and facts associated with psychoactive drug use and abuse.

The 600-page text contains information on more than 100 drugs of abuse on such things as their long- and short-term effects, classification, street names, appearance, and the degree of dependence and tolerance a user can have.

The book is aimed at judges, lawyers, physicians, social workers, and other health professionals who regularly come in contact with drug abusers and who need quick and easily understood information on the subject, says Michael Jacobs, PhD, of the ARF, who was the book's senior scientific writer.

The book's other authors are Terry Cox, coordinator of the research secretariat of the ARF, Dr Joan Marshman, ARF president, and Dr Eugene LeBlanc, director of the Ontario ministry of health's research branch.

"Our major goal with this book is to present objective, up-to-date information on virtually any drug abused in our society," Dr Jacobs told **The Journal**.

Dr Jacobs says there have been cases where the judge or lawyers aren't familiar with the drug being discussed in court. The book, which covers drugs ranging from nutmeg and caffeine, to heroin and cocaine, should help prevent that from happening in the future.

The project of compiling this information began in the 1970s after judges from York County in Ontario approached the ARF suggesting such a reference book would help them when dealing with alcohol and drug-related cases, says Dr Jacobs.

In the book's foreword, Judge Arthur C. Whealy writes "the easily readable language should demystify a subject which ought to be widely understood by the whole justice community."

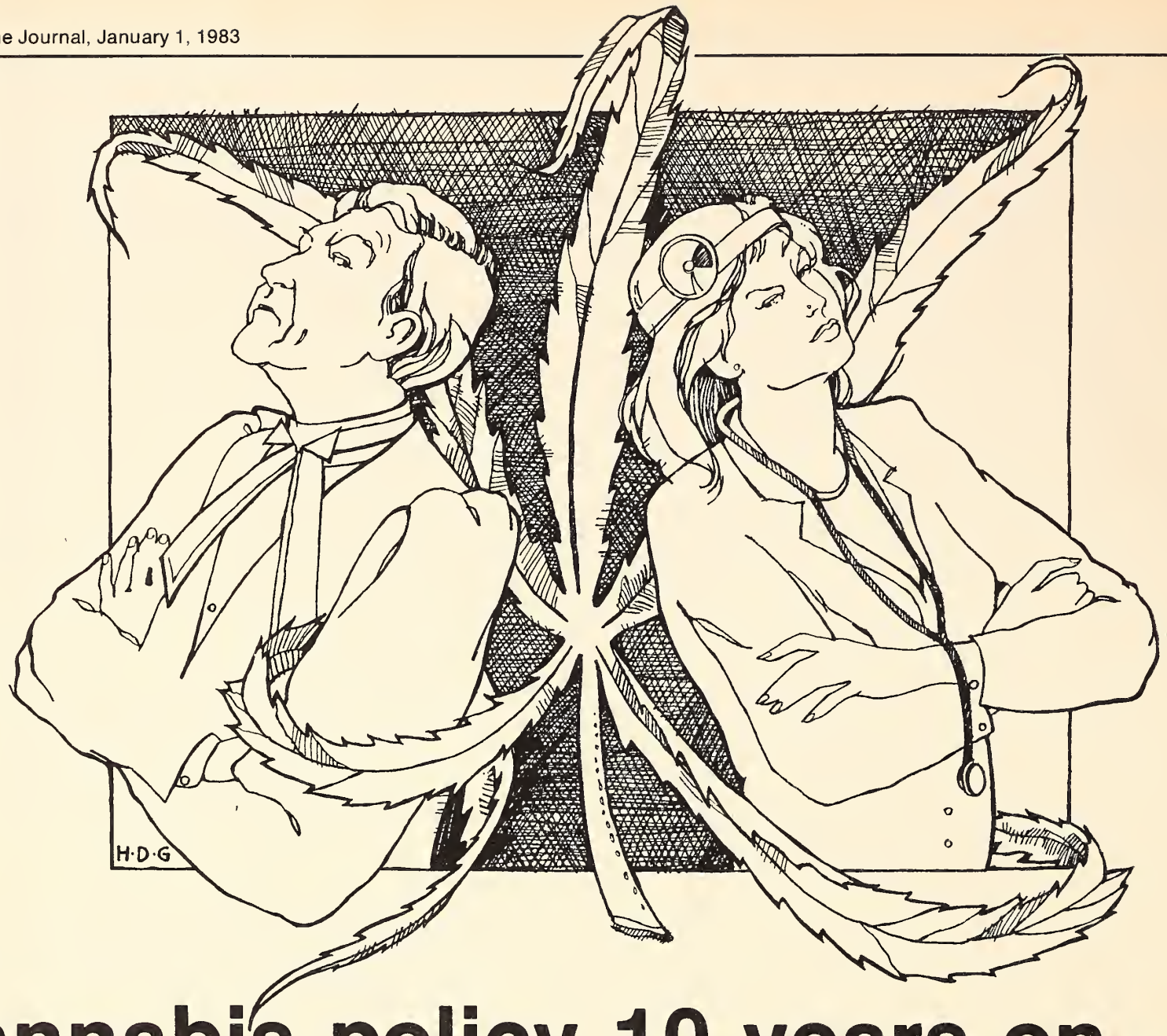
Dr Jacobs says it should also be valuable for physicians who are unfamiliar with drugs of abuse and their effects. The book may also give drug users a clearer picture of how the various substances they use can harm them, he adds.

Money for treatment work will be topic at US meet

WASHINGTON — A national conference on financing of alcohol and drug treatment services will be held by the Alcohol and Drug Problems Association of North America (ADPA) in Chicago, February 27-March 1.

The conference will consider treatment programs, insurance plans, and fund raising.

This meeting will be immediately followed by a three-day conference on alcohol and drug abuse programming in colleges and universities.



Cannabis policy 10 years on — the decade since LeDain

By Dick MacDonald

While the medical and scientific communities have been firming up their positions toward cannabis in the decade since Gerald LeDain produced his report of the Royal Commission on the Non-Medical Use of Drugs, social and legal questions remain largely unanswered.

Health and safety concerns dominate the cannabis debate. Government authorities weigh political sensitivities, aware that the whole subject of use and control provokes strong opinion and emotion. And RCMP Commissioner Robert Simmonds is able to tell the Commons justice committee that street use of marijuana is no longer a subject of active investigation.

Significant legislative reform, recommended by the LeDain Commission in the early 1970s, and by periodic governmental reviews and calls for change by such authoritative bodies as the Canadian Medical Association and the Canadian Bar Association, remains as elusive as ever.

To be precise, despite a forthcoming education campaign on drug use, (**See story page 1**) and despite cabinet ministers' assurances that changes to the law are imminent, no fresh Canadian public policy on cannabis has emerged.

The issue is put forward in a new paper (now being reviewed for publication) by three people who have given cannabis much study — Robert Solomon, of the University of Western Ontario's faculty of law, and Eric Single and Patricia Erickson, of the Ontario Addiction Research Foundation's division of social and biological studies.

They say the goals of cannabis policy should be to minimize the harm resulting from both cannabis use and the efforts to control it. Based on this standard, "the current law can no longer be considered an acceptable option."

Their paper says the law "has generated substantial financial costs, consumed a sizeable proportion of the criminal justice system's resources, and burdened tens of thousands of young Canadians with a permanent criminal record for conduct which is commonplace among their peers."

H. R. S. Ryan of the faculty of law at Queen's University shares that view. He suggests that, on balance, "the greater harm results from attempted enforcement of the law."

Marc Lalonde, when he was health minister in 1978, wondered "whether you can continue to have a law that is really rejected by such a large number of your citizens."

It seems clear the law has not stemmed the flow of cannabis into Canada. Nor, according to many reports, has the law significantly deterred cannabis use. Today, the vast majority of offenders are fined — only about 10% receive jail terms. Nonetheless, it has been estimated that more than 300,000 Canadians have acquired criminal records during the decade the federal government has been promising legislative change.

Mr Solomon and Drs Single and Erickson say simply that, "the current control regime may be characterized as one which provides only marginal benefits at tremendous costs."

The LeDain Royal Commission foresaw this condition, beginning with an interim report in 1970 and ending with the final report in 1973. The Commission concluded that there was, at that time, adequate scientific evidence to indicate the probability of harmful effects of various kinds from cannabis use. But the majority of commissioners said the risk was not high enough to warrant the difficulties and potential or actual injustices which could result from drug control laws.

The majority recommended that the personal use of marijuana and hashish — and possession of it for personal use — should not be a criminal offence, but should be transferred to the Food and Drugs Act, which imposes milder penalties than narcotic control laws.

One commissioner thought the legislation should not be changed because the risks were serious enough to warrant staying with strict sanctions. That commissioner, Ian L. Campbell, now principal of Renison College at the University of Waterloo, says he holds to his minority position.

"It is naive to think we know all the answers on cannabis," says Mr Campbell. "We've made some tragic errors in changing laws vis-a-vis youth, notably lowering the legal drinking age . . . and we're paying a high social cost."

Another minority report was presented by Marie-Andrée Bertrand, a criminologist at Université de Montréal. She felt then, and still holds the view, that the infringement of civil liberties is more important than the risks involved in cannabis use.

Ms Bertrand still argues that the harm done by prison sentences to young users outweighs the gravity of the medical risks involved. She recommended that possession and personal use be legal, and sale of the drug be carried out through a government monopoly similar to that for the sale of alcohol.

(Former commission chairman Gerald LeDain is now a member of the Federal Court of Canada and says he cannot comment on cannabis policy.)

Questions dealt with by the LeDain Commission at the beginning of the 1970s remain central in the debate about a new cannabis policy. Under the Commission's microscope, for instance, was the individual's relationship with the state — at what point is he no longer independent of society, at what point does the state have responsibility for his well-being, and what is the role of the mass media in social change.

The commission moved very quickly from a relatively simple inquiry into the non-medical use of drugs toward a social study of broader dimensions.

The commission served as a meeting ground for ideas and opinions. It was a watershed of wisdom, but in the end it was largely ignored by policy-makers. It did, however, attract the heat of public anxiety at the time.

In examining cannabis control policy in 1980, the team of Solomon, Single, and Erickson suggested the existence of risk *per se* should not dictate the legislative response. "Ultimately, the question becomes one of selecting the possession option and related control methods that provide the greatest risk reduction at the lowest level of social costs and adverse individual consequences." (**The Journal**, Nov, 1980)

Presumably, federal authorities have used the same premise, as they have sporadically stated their intention to introduce new cannabis legislation.

Solicitor-General Robert Kaplan said recently the subject is before Cabinet and indicated the criminal law would continue to be used to curb marijuana consumption "because we think it's harmful."

Justice Minister Mark MacGuigan has said he hopes to introduce amendments in the new session of Parliament — but, in 1970, then-health minister John Munro said much the same thing.

In the meantime, Health and Welfare Canada poises to launch its nation-wide public education program on substance abuse in March.

Belated as it may be, the education program brings some small comfort to LeDain Commission members. Their final report of 1973 contained a dozen specific recommendations for far-reaching public information projects.

"Better late than never," says Ian Campbell.

Dick MacDonald teaches journalism and is co-editor of The News: Inside the Canadian Media *(Deneau, Ottawa). While a reporter with the Montreal Star, he covered much of the work of the LeDain Royal Commission on the Non-Medical Use of Drugs.*

THE BACK PAGE

Vol. 12 No. 2 2nd Class Mail Reg No 2776 TORONTO February 1, 1983

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

RCMP release drug intelligence estimates — cannabis sales pass $5 billion mark

By Mark Kearney

TORONTO — Illegal drugs in Canada generated more than $8 billion in retail sales in 1982, says Superintendent Rod Stamler, officer in charge of the Royal Canadian Mounted Police (RCMP) drug enforcement branch.

He says the figure is a "conservative estimate," because law enforcement agencies can only rely on the information gained by intelligence investigations, consumption and production estimates, and drug seizure and arrest statistics.

Supt Stamler was commenting on information contained in the RCMP National Drug Intelligence Estimate, the first report of its kind in Canada. It attempts to present a "review of the origin, volume, trafficking routes, modes of transport, and smuggling methods of all drugs on the illicit Canadian market."

The statistics in the report are for 1981 and are the latest available. Supt Stamler says the $8 billion in retail sales of drugs in 1981 increased in 1982. Sales of heroin, especially, contributed to the increase.

The report notes cannabis accounted for more than $5 billion in sales in 1981, heroin for $2.25 billion, cocaine $475 million, and chemical drugs $275 million.

Supt Stamler says the 150-page report is intended to help the public and government officials understand the magnitude of the drug problem in Canada.

He says it's important the RCMP present the information in a single report; it should help determine the problems facing law enforcement, analyse changes that have occurred, and estimate possible future trends.

The report should also help the RCMP and policymakers identify priorities and approaches to anti-drug campaigns, and generate discussion on how to deal with Canada's drug problem.

"We don't have all the answers," Supt Stamler adds.

The report provides detailed chapters on heroin, cocaine, chemical drugs, and cannabis. For each drug, information is given on abuse and availability trends in Canada for the past five years, developments in source countries, how the drugs are distributed, the cost, and the amounts seized.

It notes, for example, the growing importance of Southwest Asia as a source for heroin (**The Journal**, Nov 1982), the prominence of Lebanon as a source of hashish because of political unrest there (**The Journal**, Sept 1982), and the increased use of cocaine in Canada, not just among upper-income groups but throughout society.

It also points to the dramatic change in drug costs from source country to street price in Canada. For example, a farmer in South America may sell 250 kilograms of coca leaves for $1,000. That amount of coca leaves would produce 2.5 kilograms of coca paste worth $3,600.

The coca paste, in turn, produces one kilogram of cocaine base worth about $9,500, and that can be processed into one kilogram of cocaine hydrochloride which sells for $18,000.

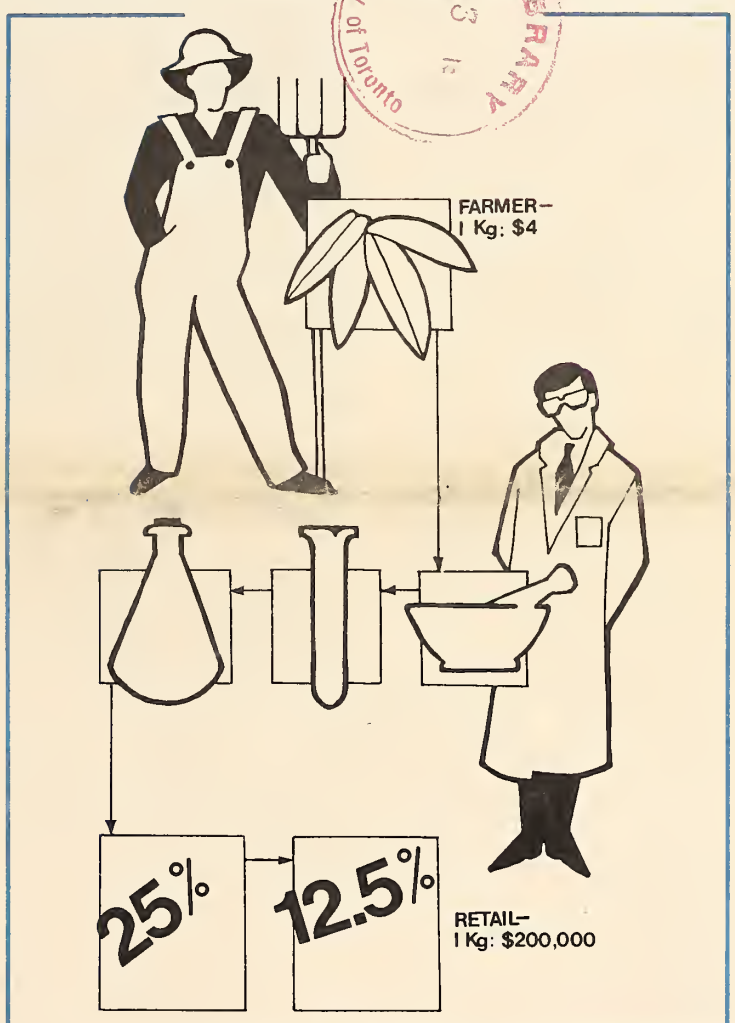
Once it reaches Canada, that pure kilogram of cocaine hydrochloride wholesales for $100,000. Dealers can then turn that into eight kilograms of 12.5% purity by cutting it with other substances, and it will fetch about $1.6 million on the street.

In other words, the farmer on average gets $4 for each kilogram of coca leaves he produces and the dealer receives $200,000 for each kilogram of 12.5% pure cocaine he sells.

Supt Stamler says drug trend predictions up to 1984 contained in the report will serve as an accuracy check after data are collected for the next two years.

A weakness of the report is that the "latest" statistics are for 1981. Supt Stamler says that's the most recent information the report can provide because it's the first such collation done. He expects future reports will contain more up-to-date statistics.

The report will be distributed in various countries — including those where drugs are produced — which already receive the RCMP's monthly trend report, Supt Stamler says.



From coca leaf to gold dust

Drug income rises dramatically from source to street sale. Processed and cut to 12.5% purity, cocaine sells for about $200,000 per kg on North American streets. For his coca leaves, the South American farmer got $4 per kg.

Convictions for cocaine on increase

OTTAWA — Convictions in Canada involving cocaine have jumped 30% in a year, say the latest statistics from the health and welfare department.

The number of convictions increased to 1,076 in 1981 from 823 in 1980. The large majority of those convictions were either for possession or trafficking; more than half the offenders were males between the ages of 20 and 29 years.

Convictions involving heroin, however, declined 27% to 217 in 1981 from 298 in 1980. Approximately two-thirds of those convictions were either for possession or trafficking, and almost half the offenders were males between the ages of 20 and 29 years.

These and other statistics are contained in the recently-released publication *Drug Users and Convictions Statistics*, 1981. It reflects arrests and convictions under the Narcotic Control Act, the Food and Drugs Act (parts III and IV), and drug-related offences under the Criminal Code of Canada.

The report notes convictions involving LSD (lysergic acid dyethlamide) and cannabis remained relatively stable in that year. LSD convictions dropped to 1,891 in 1981 from 2,003 in 1980, and cannabis convictions increased to 40,668 from 39,937.

Convictions involving opiates and opiate-like drugs such as hydromorphone and oxycodone dropped to 488 from the 1980 total of 589.

However, Health and Welfare Minister Monique Begin says the report shows the use of psychoactive drugs for non-medical purposes remains "a serious health and social concern in Canada."

US alcohol agency sets sights on new, young investigators

By Harvey McConnell

WASHINGTON — Guidelines for research projects which it is hoped will bring in new, young investigators have been prepared by the United States National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Loren Archer, NIAAA deputy director, told **The Journal**: "We need to spell out that research in the alcoholism field includes such things as prevention, employee assistance, and treatment. We need to encourage young investigators, and we are ready to provide special funding for them."

Mr Archer notes past research has been done by those with a reputation: "Because you have a reputation you thus get approved. We want to begin to build up young investigators so they can gain reputations."

Much research has been in the biomedical sector and, from a practical standpoint, the emphasis has been on laboratory investigations, which will produce better scores than good clinical research which is more difficult to do.

Thus, Mr Archer points out, many investigators capable of doing good laboratory and clinical studies have concentrated on laboratory investigations because they knew it would be easier to be funded.

Mr Archer adds: "We want to

(See — NIAAA — page 2)

Forecast '84 — drugs international

The Back Page

INSIDE

UN drug treaty under study — p 9

NEWS

Briefly. . .

Traffickers hanged

IPOH, Malaysia — Courts here are getting tougher with drug offenders. Three traffickers hanged in December, 1982, brought the year's total to 23 executions for such offences. Fifteen of those executions took place between October and mid-December. The offenders hanged in December were convicted of trafficking 7.5 pounds of morphine and 6.4 pounds of heroin.

Burp not refusal

OTTAWA — Maxwell White has burped his way out of a charge of refusing to take a breath test. The Supreme Court of Canada has refused an appeal against earlier judges' decisions that burping doesn't constitute a refusal. Mr White was arrested in Stephensville, Nfld, and began burping en route to a Royal Canadian Mounted Police (RCMP) detachment office. The RCMP refused to administer the test while he was burping because it might result in an incorrect high reading. Although Mr White told them he couldn't stop, he was charged with refusing to take the test. The judges ruled that Mr White never actually refused to take the test; he just couldn't stop burping.

Sleep it off

LONDON — A new pressure group here wants those who are drunk and disorderly to be dried out in community centres and not tried in court. The group, Out of Court, Alternatives for Drunkenness Offenders, is supported by more than 20 organizations dealing with drink-related programs. Under the group's proposal, anyone impaired would go, or be taken, to a centre to sleep it off rather than appear before a magistrate faced with a criminal charge.

Abstinence — totally

LONDON — On this, the 150th anniversary of the signing of the first pledge of abstinence from alcohol, teetotallers may want *not* to tip their glasses in celebration, and reflect on how they got their name. It seems one of the first to enlist in the abstinence cause was Dickie Turner, a fish-hawker by trade, who spoke at meetings during a public tour despite a speech impediment. Asked if temperance meant drinking in moderation, he replied "t...tee... totally," and added a new word to the English language, says the newsletter of the Federation of Alcoholic Rehabilitation Establishments.

UK steps up control

LONDON — Amphetamines soon may be added to the list of drugs covered by Britain's Misuse of Drugs Act if the General Medical Services Committee has its way. The committee, on the heels of recent recommendations by the Advisory Council on the Misuse of Drugs, has agreed that amylobarbitone, butalbital, butobarbitone, cyclobarbitone, heptabarbitone, methylphenobarbitone, pentobarbitone, phenobarbitone, and quinalbarbitone should become controlled drugs. It also believes no authorized doctors should prescribe, administer, or supply dipipanone to anyone suspected of being addicted, except for treatment of organic disease or injury.

More tough than effective, says former White House advisor

Bourne attacks Reagan drug policy

By Mark Kearney

ATLANTA — The Reagan administration in the United States is ignoring the "real drug problem in America" despite the fact heroin overdose deaths are as much as 15 times what they were four years ago.

This is the view of Peter Bourne, once one of the most powerful and trusted voices in the US substance abuse field.

"If the ability to save the lives of the several hundred people who die each year from drug abuse is not the bottom line of any realistic, national drug policy, I do not know what is," he told a conference here.

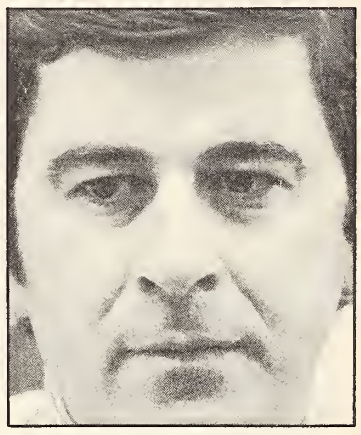
In the 1970s, Dr Bourne, a psychiatrist, was special adviser on health issues to then-president Jimmy Carter. He was considered by many in the field in the US their personal link to the president. His resignation in 1978, after it was revealed he had written, for an aide, a prescription for 15 methaqualone tablets and had used a pseudonym instead of the aide's real name, sent shock waves through the field. (**The Journal**, Aug 1978).

Speaking in Atlanta to the south eastern conference on alcohol and drug abuse, he accused current health officials of "monumental cynicism" in formulating policy, and "an apparent attitude that these deaths constitute good riddance."

He said the real drug problems are overdose deaths, escalating property crimes committed by desperate, addicted individuals, and incapacitating dependence on pharmaceutical products. The administration, however, is more concerned with the widespread teenage use of marijuana which is "relatively benign and has yet to produce its first fatality from drug effect alone.

"I would be the last to suggest this should be entirely ignored or that we should not be discouraging the use of any drug by young people.

"However, to address this aspect of the problems as the top priority is like treating the common cold as America's number one health problem, when millions die each year from cancer, heart disease, and stroke."



Bourne: monumental cynicism

He said one reason for the dramatic rise in overdose deaths is the reduction in federally-supported treatment programs. For example, the budget for the US National Institute on Drug Abuse which was $260 million in 1979 is only $60 million this year.

"So dramatic is the cut in the number of treatment slots that for the first time in 10 years the federal strategy fails even to address the issue," Dr Bourne said.

This attitude is part of a dramatic shift in the public's perception of the alcoholic and drug abuser, he said.

Until two years ago, drug and alcohol abuse officials believed "the American people finally understood alcoholism was a disease, and society's best interests were best served by making sure they (alcoholics) received the same degree of help and understanding they would with any other physical condition.

"Suddenly the visibility of the alcoholic and drug abuser has become a liability, and society has turned with a vengeance, making them a scapegoat."

He cited groups such as MADD (Mothers Against Drunk Driving) as influencing politicians to propose legislation that seems more motivated by revenge against drunk drivers than by a desire to solve the problems of alcoholics and drug abusers. There has also been increased pressure on states to raise the legal drinking age to 21 years when evidence suggests this "would result in the opposite effect of what is intended."

Dr Bourne did praise President Ronald Reagan and Mrs Reagan for drawing attention to the problems of drug and alcohol abuse but said it's a "tragedy" they have also fostered the view that drug abuse is a moral rather than a health problem.

He said while President Reagan's fight against drug traffickers is also commendable, "unfortunately the $200 million he is willing to allocate for this purpose has more impact in showing he is tough than in being cost effective."

Kids at alcoholism risk undetected by blood acetaldehyde level tests

By Harvey McConnell

WASHINGTON — Blood acetaldehyde levels cannot be considered a possible marker for future alcoholism among children of an alcoholic parent or parents.

A group of children considered at risk, and many of whom had psychological problems, could not be differentiated from matched controls after exposure to alcohol in a study by the United States National Institutes of Health and the Uniformed Services School of Health Sciences in nearby Bethesda, Maryland.

The team points out there is reliable evidence of increased risk of alcoholism developing among children of an alcohol parent or parents.

Blood acetaldehyde levels following drinking have been a putative biomedical marker because such levels are higher in alcoholics than in non-alcoholics who are given measured doses related to body weight. In addition, levels have been reported higher for college age — but non-alcoholic — sons of alcoholics than for sons of non-alcoholics.

In the study, 11 boys aged eight years to 15, and with one or both parents considered a primary alcoholic, were compared with 11 age-matched controls whose parents had no such problems.

Among the 11 at-risk children, five were considered normal. Problems among the other six children included lifetime history of attention deficit (3), problems in conduct (2), oppositional disorder (3), and major depression (1). Among the controls, one had a problem with attention.

All of the children had had previous contact with alcohol, although for most it was the first time they had an "intoxicating" dose.

The 22 children were tested for standing steady, memory, and subjective moods. Pulse rate, breath alcohol and acetaldehyde concentration, platelet monoamine oxidase (MAO) levels, plasma norepinephrine and epinephrine, cortisol, and opiate-like activity levels were determined.

The children were tested in pairs — subject and control — and given 0.5 ml/kg of pure alcohol mixed with a soft drink. Measurements were taken and repeated over a five-hour period.

Changes in memory and mood were observed at peak blood alcohol levels at 30 minutes in both groups.

The researchers found no difference between the at-risk children and controls in levels of breath alcohol, breath acetaldehyde, blood acetaldehyde, cortisol, platelet MAO, and opiate-like activity levels.

There were no differences between the two groups in other measurements, although striking individual differences were found in the reactions of all the children to their first large drink.

The study was presented here at the conference of the American Academy of Child Psychiatry by co-author Dr David Behar, then of NIH, now of department of psychiatry, Veterans Administration Hospital, Philadelphia.

NIAA makes offer

(from page 1)

develop research in areas which will be particularly useful for the practitioner, whether in prevention, early intervention, or treatment. Then it is most important to get this information disseminated and in ways people can understand how to use it."

A major reason for encouraging new research is that the alcoholism, and to a lesser extent drug, field is one of the few where there have been increases in the Reagan budget.

Mr Archer says there is a lot of misunderstanding in the field about psychosocial research projects funded by the institute. Many believe, mistakenly, that it cannot be done.

Mr Archer: "The only things you couldn't do in the psychosocial field was something which had nothing to do with alcoholism.

"For example, we are not interested in, say, funding research on Andean brothels, unless it has some impact on alcoholism or alcohol abuse. We don't think that is an unreasonable standard.

"However, a lot of people have misunderstood that and said you couldn't do any psychosocial research. That is not true, but the research must be in the field of alcoholism and alcohol abuse."

BC freon death sparks call for propellent ban

By Eleanor LeBourdais

SURREY, BC — The death of a 13-year-old girl who inhaled an aerosol cooking spray has encouraged a call for legislation here to ban aerosol sprays and their propellent — freon.

The girl died of sudden cardiac arrest after spraying the liquid into a plastic bag and inhaling it. Friends of the girl testified at an inquest into the death that after the first sniff the girl started to cry, got hysterical, became delusional, and passed out. The friends tried mouth-to-mouth resuscitation, but were unable to revive her. She was taken to hospital where she subsequently died.

A pathologist testified the aerosol propellent freon goes directly to the heart muscle and makes the heart fibrillate rather than pump, resulting in a lack of oxygen supply to the brain. The difference in the amount required to achieve a "high" and that which can be fatal is "a matter of seconds."

The inquest jury urged the British Columbia consumer affairs ministry to take steps to eliminate use of the aerosol propellent freon, and suggested the government should prohibit sale of products containing undiluted freon to minors. The jury also suggested aerosol products should be labelled with warnings about the hazards of inhalation of the products.

'A problem like nothing we've seen before'

Mayer predicts rise in stimulant abuse

By Betty Lou Lee

OAKLAND, CA — Stimulants may become the most serious substance abuse problem in the history of the United States, the administrator of the Alcohol, Drug Abuse and Mental Health Administration predicts.

"It's my personal belief, and I may be dead wrong about this, that . . . cocaine, amphetamines, and amphetamine-like substances may prove to be the most serious and significant drug abuse problem we have ever faced," William Mayer, MD, said.

"We have never had another chemical or set of chemicals that has as its advocates such splendid American heroes: the football players, the actors, and the people who are the glamor set.

"We have never had that kind of endorsement, in spite of the best efforts of the liquor advertising business, the best efforts to glamorize the use of alcohol and to identify it with sexual success and beauty and joy, all of which I suppose it can be identified with at times.

"They haven't done nearly as effective a job as threatens to be done by the people who are using those stimulants which are so in keeping with the North American character, so in keeping with the striving to get ahead, the being alert, the steel-trap mind, the staying awake for examinations, the sense of adequacy and mastery that has characterized many of the achievers of this country in its short history.

"So I think that if cocaine becomes even more available, and at more reasonable prices, we're going to have a problem like nothing we have ever seen before."

Dr Mayer was speaking at An International Perspective on Substance Abuse held by the Association for Medical Education and Research in Substance Abuse (AMERSA) and the World Health Organization.

He cited increases in federal funding as an indicator of the administration's commitment to combatting abuse.

While the US National Institutes of Health got a 2% over-all increase this fiscal year, the US National Institute on Drug Abuse (NIDA) got 17% more, and the US National Institute on Alcohol Abuse and Alcoholism (NIAAA) got 58% more, "more than any other element in health.

"We are now being dealt with exactly like NIH in personnel and monetary requirements. Granted, we're starting from a smaller base, but no other area of health, even including syphillology, has had to deal with such an enormous heritage of misinformation, superstition, and judgmental putdowns.

"We see now in the federal establishment a great deal of vitality, particularly focusing on drugs and alcohol for the first time."

But, Dr Mayer warned, "there isn't going to be, in the foreseeable future, the steady escalation in support we've experienced in mental health, drugs, and alcohol over the past 10 years . . .

"What is called for now is rethinking, retrenching, the development of consensus about some of the questions I've asked (about diagnostic criteria and best treatment methods) . . .

"Admittedly, as of now, there's no pretense that it's ultimate truth, but the best of what the best of us can come up with.

"Questions are being asked, and we have to give a sensible answer. I don't want answers to come through up to my organization that are the answers of a biased few. I want them to be the best thought-out, most sensible, collaborative ideas that intelligent men and women can come up with."

Carlton Turner, PhD, director of the White House office on Drug Abuse Policy, sounded a familiar note in another address when he appealed for a "straight line, straight talk, unambiguous message" from health professionals.

"We've taken the line that it's time for the philosophical debate to stop and for action to start. We're not using 'hard and soft,' we're letting a drug be a drug," Dr Turner said.

"We're not using the word 'responsible' use of drugs for young people. We're not using 'recreational use of drugs.' We're not saying 'substance abuser,' or 'abusing' alcohol or cocaine.

"We're trying to send a concise message to the young . . . it's time for the profession to relay to young people that the drug-taking habit is counter-productive and can have dire health consequences."

Dr Mayer, said every day drunken driving accidents alone are killing more people in that age group than all the casualties in Vietnam.

"Untold millions" were spent on polio research in the 1950s, when it was considered a national epidemic of major proportions. It killed 3,000 people a year, 200 of them in the 16 to 20 years age group.

"We're killing 25,000 Americans a year in just alcohol-related automobile accidents, 10,000 of them in that young age group."

"What three things does drink especially provoke?" asked William Shakespeare in his play **Macbeth**. *But Canadian high school students searching for the answer won't find it in their texts. That line and the answer that follows, in which Shakespeare writes of the effects of alcohol on sexual appetites, haven't appeared in school editions since 1967. The deletion was recently spotted by a Burnaby, BC, mother who accused the book's editors of censorship. They say they're innocent and claim that no one, in the past 15 years, noticed the passage was missing. For the curious, the other lines are: "Marry, sir, nose-paintings, sleep and urine. Lechery, sir, it provokes and unprovokes: it provokes the desire but it takes away the performance. Therefore much drink may be said to be an equivocator with lechery: it makes him, and it mars him; it sets him on, and it takes him off; it persuades him and disheartens him; makes him stand to, and not stand to; in conclusion, equivocates him in a sleep, and giving him the lie, leaves him."*

Indian wars whisky legacy is backfiring

OAKLAND, CA — A policy designed to protect the health of United States servicemen back in the days of the Indian Wars (late 1800s) is now having the opposite effect, says William Mayer, administrator of the US Alcohol, Drug Abuse and Mental Health Administration.

In those days, bad booze was killing more soldiers than the Indians were.

"So the government contracted for good quality whisky and sold it to the troops so when they got blind drunk, they didn't stay blind — or dead.

"To this day, we have a magnificent liquor distribution system throughout the armed forces, guarded jealously by those guardians of troop morale, which continues to sell at prices so terrific that you can't afford not to drink — a lot.

"We encourage incipient alcoholics away from home and lonely to develop alcoholism at 10 times the normal rate."

Mayer: such splendid heroes

Third Worlders mount plans to oblige Dr T

By Wayne Howell

Mr Garcia Lopez
President: Cordillera Rotary Club
Cuzco, Peru

Dear Mr Lopez:

I trust that all you good folks and civic-minded citizens at Cordillera Rotary are as excited about the latest thrust of United States drug policy as we are here at Golden Triangle Kiwanis. Now that Carlton Turner, chief White House advisor on drug abuse policy, has announced that the mood of America has changed, there is just no longer any justification for us third-worlders supplying America with illicit drugs. According to Dr Turner, decadence is now definitely "out" in America, and parents' groups and citizens' groups against drugs are "in." America is cleaning up her act and so the least we can do is clean up our act too: that is his message.

Angor Wat branch of Golden Triangle Kiwanis is proud of its response to Dr Turner's message. We think we have developed an innovative campaign to carry the message to the good citizens of the Golden Triangle. Have you done likewise? We would be interested in hearing of your experiences.

Yours truly,
Le Duc Thong
President: Angor Wat Kiwanis

Dear Le Duc Thong:

As you can well imagine, this latest revelation about the American mood caused a great deal of excitement at last month's luncheon meeting of the Cuzco Rotary Club. Once the excitement died we got right down to work. A planning committee was formed and in no time flat we came up with what we think is a unique response: our Can the Coke campaign. Every school child in the district is encouraged to tear down as many coca bushes as he can find. The child who destroys the greatest number of bushes in a week wins an all-expense-paid trip to see a soccer game in Lima, courtesy of Cuzco Rotary. We have had a bit of a problem with certain peasant farmers who have responded to the Can the Coke campaign with small arms fire. We handle this by sending the parents of the deceased child to a soccer game in Lima and putting the farmers on Carlton Turner's mailing list so that they can see for themselves where their civic duty lies. They usually feel pretty sheepish about their homicidal behavior after they are acquainted with the facts about America's changed mood.

Yours fraternally,
Garcia Lopez
President: Cuzco Rotary

Dear Garcia:

It was good to get your letter. I am grateful for your suggestion of putting recalcitrant citizens on Carlton Turner's mailing list, because until now Angor Wat Kiwanis has been at a loss as to what to do about our Golden Triangle citizens who are not cooperating with the Angor Wat Kiwanis Pull a Poppy campaign, despite the fact that every poppy-puller gets to put his name in the big bronze drum (donated by Angor Wat Hardware), and thus becomes eligible for the Angor Wat Kiwanis Bangkok Bonus Weekend. But there is a problem. It is impossible to put many of our Golden Triangle citizens on a mailing list because they have no fixed address. Any suggestions?

Yours fraternally,
Le Duc Thong

Dear Le Duc Thong:

I think I have the answer for you. I recently received a letter from Omar Saikaliy, president of the Cedars of Lebanon Lions Club, and currently co-director of the Beqaa Valley Lions Trash the Hash campaign. He says Carlton Turner plans to have the US Information Agency carry the news about America's new mood around the world. So I would suggest that you recommend to your itinerant Golden Valley citizens that they tune their short-wave radios to US Information Agency broadcasts. Once they get the word, I am sure they will pitch in and root every poppy out of the Golden Triangle. Golly, if they don't, then Dr Turner's going to be some mad at us third-worlders for letting all those parents groups in America down.

Fraternally yours,
Garcia Lopez

NEWS

RESEARCH UPDATE

Alcohol tests unreliable in pregnancy

Two common indices of alcoholism — mean cell volume (MCV) and gamma-glutamyl transpeptidase (GT) — are not reliable in detecting potentially harmful rates of drinking in pregnant women, say doctors at the Charing Cross Hospital in London, England. They measured the MCVs and level of gamma GT in the serum of 16 women with a drinking history and noted the changes during pregnancy. Raised levels of gamma GT were found in 12 of the 16 women in the first trimester. Six continued to drink heavily during pregnancy but in only one person was the level still persistently raised. The doctors report that none of the women had a raised MCV even though six were known to have had elevated levels in the past. This may have occurred because of a relative iron deficiency in the first trimester. MCV and gamma GT are often used as tests to detect alcoholism.
British Medical Journal, Nov 6, 1982, v.285: 1318

Summer best for education

The best time of year to launch an anti-drinking campaign is summer, suggests a Finnish scientist. Kari Poikolainen of the medical research council of the Academy of Finland says a study of alcohol-related hospital admissions over six years showed numbers were significantly higher in summer and autumn months. Among males, alcohol poisoning and alcohol psychosis were significantly higher in June. Similar increases for admissions for pancreatis occurred from July to September, for alcoholism from September to October, and for liver cirrhosis in October. Among females, there were significant increases in admissions during the summer for alcohol poisoning, alcoholism, and liver cirrhosis. Dr Poikolainen says campaigns will work best just before admissions increase. They might include health education programs, temporary price increases, and restriction on alcohol availability. He says the role of psychiatric factors in the seasonal variations needs to be clarified as they have implications for planning and implementation of preventive measures.
Drug and Alcohol Dependence, 1982, v. 10: 65-69

I said, "Do you want a cigarette?"

Long-term cigarette smoking is frequently associated with diminished hearing, suggests a study carried out by two Cairo University researchers. Dr Amal Ibrahim, an epidemiologist, and Dr Ahmed Fatthi, an otolaryngologist (ear, nose, and throat specialist), studied 150 smokers, average age 42.9 years, and 150 non-smoking controls, matched for age, educational background, and socioeconomic level. While 83% of the non-smokers had hearing in the normal range, the same was true of only 30% of the smokers. Among the non-smokers, 3% showed signs of conductive deafness (hearing loss due to impaired conduction of sound waves to the inner ear) and 13% had some degree of perceptive deafness (hearing loss associated with the inner ear, the auditory nerve, and auditory centres in the brain). Among the smokers, on the other hand, 21% had some degree of conductive deafness and 49% showed signs of perceptive deafness. On average, the non-smokers showed a 9% hearing loss, compared to 25% in smokers. Smoking may have its effect on hearing by promoting atherosclerotic narrowing of blood vessels, including those supplying the inner ear, the researchers suggest. They also point out that irritation produced by cigarette smoke can cause changes in the mucous membranes of the nasopharynx, the eustachian tube or auditory tube, and the ear drum.
Canadian Family Physician, Sept, 1982, v.28:1704.

Hepatitis B carriers should abstain

Chronic, symptomless carriers of hepatitis B (HBsAg) should be advised to abstain from alcohol, suggests a study from the University of Modena, Italy. Although overall incidence of chronic hepatitis in such subjects is low, the researchers wanted to compare the possible hepatotoxic effect of chronic ingestion of differing amounts of alcohol in these carriers with that in a matched group of HBsAg-negative blood donors. The subjects were categorized by their daily ethanol consumption and followed up for 3½ years. The researchers found that only a few controls had liver abnormalities and that the proportion didn't rise until more than 80 g of ethanol was consumed daily. However, a substantial proportion (23.4%) of HBsAg-positive subjects had liver abnormalities even when drinking was low (0-19 g daily). That proportion rose significantly (46.3%) when consumption exceeded 60 g daily. "These observations suggest that for a given amount of alcohol ingested the risk of hepatic disease is higher in HBsAg carriers than in HBsAg-negative subjects," the researchers conclude. "The part played by ethanol, even in moderate amounts, should be carefully evaluated."
The Lancet, Dec 4, 1982, v.11: 1243-1244

Alcoholics getting fit?

Alcoholics placed in a fitness program in addition to participating in standard psychological therapy showed a better abstinence rate at three months' follow-up than similar alcoholics who didn't take part in a fitness-raising regimen, reports a Montreal research group. In fact, abstinence in the exercisers was 69% at three months, nearly double what it was in comparison groups. However, the three-month follow-up also showed that very few of the alcoholics — average age 42, 60% employed at start of treatment — stuck to a fitness regimen after the six-week program came to an end.
Journal of Studies on Alcohol, 1982, v.43:380-385.

FAS information campaigns should go to public at large

By Mark Kearney

TORONTO — The general public and not just mothers-to-be have to learn about the risks associated with drinking during pregnancy, says the head of the nutrition and weight loss program at the Donwood Institute here.

Patricia Kelly says without a broad-based campaign, many women could be drinking in the early stages of pregnancy without realizing the possible danger it creates for the unborn child.

"Information about alcohol and pregnancy needs to be general information and not just a part of prenatal counselling, since many women do not know for the first month or so that they are pregnant, and may not seek medical attention until much later."

Surveys show that 70% to 80% of pregnant women drink some alcohol during pregnancy, she said at the Ontario Hospital Association conference here. This puts a large proportion of pregnant women at risk for having children with fetal alcohol syndrome (FAS), Ms Kelly adds.

Although health professionals have to be knowledgeable about FAS, media campaigns should have messages where everyone can see or hear them — on television, radio, newspapers, billboards and posters, in liquor stores, and on public transportation, she says.

One difficulty with providing information is that study findings are not consistent. Some studies have shown higher incidences of abnormalities in infants born to women who had one or more drinks, others report no such increase when mothers are moderate or heavy drinkers.

"The difficulties encountered in accurately assessing intake, allowing for individual variation in metabolism of ethanol and patterns of use, and determining the relationship between alcohol and other factors may preclude the possibility of ever setting a safe level" of drinking during pregnancy, she says.

Because the evidence is inconclusive, Ms Kelly advises any woman pregnant or contemplating pregnancy not to drink.

"If there is any risk at all, why take that chance?"

It's better late than never for pregnant women to cut out alcohol

By Dorothy Trainor

MONTREAL — Women might better stop drinking late in pregnancy than not at all.

Beneficial effects of stopping well into gestation were suggested in a sample of 94 prenatal care patients at Grady Memorial Hospital, Atlanta, Georgia.

Forty-eight percent of the women were drinking at first interview and voluntarily abstained for the balance of pregnancy. The remainder constituted the "alcohol group." Fifty-five percent of the abstainers were already in their second trimester.

A team headed by Iris Smith, MCH, reported to the American Public Health Association's annual meeting here that there was a significant gain in intrauterine growth for the infants of abstaining mothers as compared to infants of the drinking mothers.

Mean infant birthweight for the abstainers' offspring was 3,032 gm and 2,575 gm for non-abstainers. Birth length was also greater in infants of non-drinkers. Head circumferences were not significantly different.

The two infant groups did not differ in terms of Prechtl Neurological Examination scores.

They're supposed to be role models of sobriety

Counsellors tough patients

By Lynn Payer

NEW YORK — Alcoholism counsellors are about the toughest of any professional group to treat for impairment, says LeClair Bissell, president of the American Medical Society on Alcoholism.

"Just about anyone else, an anesthesiologist or a nurse, you can send to treatment, get them back, monitor them carefully, and have them back to work in a month," she told a panel during the Women and Work conference here.

But if alcoholism counsellors are recovered alcoholics or ex-addicts, "one of the conditions of employment has been a minimum of two years continuous free and dry . . . Part of their job is to function as a role model of successful sobriety, or a person who is clean, for the patients. That credential is the equivalent of his or her licence."

In a large treatment facility, Dr Bissell said, the counsellor who has slipped can be taken out of direct patient care and placed elsewhere. In a smaller facility, "if I ask you to turn in a colleague who's slipping, I may be asking you to cost that person their job."

Dr Bissell, who is writing a book about alcoholic professionals, pointed out, as did other panelists, that health professionals may be among the last to develop employee assistance programs, and that such programs tend to come later to professions dominated by women.

She said while priests were the first professionals to develop programs for their impaired colleagues, doctors were the first health professionals to do so. Although the term used then was disabled doctor, "we had a great brouhaha from the people in wheelchairs who said that the word disabled applied to nice people who were physically ill and should not be applied to those nasty people who were crazy and had alcoholism and addiction.

Bissell: psychiatrists have edge

"We looked for a word that nobody could lay claim to. Nobody wanted to be called impaired so we got that."

In response to a question on which specialties had more impairment, Dr Bissell said "insofar as it's been studied, psychiatrists seem to have a slight edge. It's my own hunch, if you'll let me pool several studies, that the next group in medicine is the Ob-gyns (obstetricians and gynecologists)." She said the usual explanation is that they usually did obstetrics early in their career and their gynecology later. Not only did the hours of obstetrics tend to favor alcohol abuse, but "you can deliver a baby at any hour with alcohol on your breath and it's accepted."

Nurses suffer from the lag in employee assistance programs seen in female-dominated professions. "We have impaired physicians programs, at least on paper, in all 50 states. To the best of my knowledge, only eight or nine state-level programs for nurses are even semi-operational."

Should professionals have their own special treatment programs? "I have a lot of misgivings about special programs for any profession where our specialness is emphasized and we're separated from the rest of the human race. I think it's one of our big problems — I think we need treatment with everybody else."

She said halfway houses, where physicians live together and support each other in the reentry period, are promising. "I'd like to see things like this for nurses and other professionals."

She emphasized that clear separation should be made between those whose job is to coerce professionals into treatment and those who actually treat them.

"I am highly mistrustful of people who make their living treating addicted professionals. . . . If you're going to do the treatment, don't be the coercer — if you're going to be the coercer, don't do the treatment."

'A powder keg with a very short fuse'

UK customs seizing record amounts of heroin

By Harvey McConnell

LONDON — Heroin as much as 90% pure is being sold on British streets, but overdose deaths remain low because most addicts now smoke or sniff the drug instead of injecting it.

A record 176.34 km of heroin was seized by UK Customs and Excise officers in 1982, most at Heathrow, London's main airport. Almost all the heroin came from Pakistan.

"We in the United Kingdom are countering the smugglers quite well, but we are sitting on a powder keg with a very short fuse," Peter Cutting, chief customs investigating officer said.

Mr Cutting pointed out the increase in seizures is massive — up 102% in 1982 over 1981, and 1981 was up 128% over 1980. However, this does not represent a proportional increase in worldwide trafficking or in the amount hitting the streets in Britain.

"It is unprecedented international cooperation" which is responsible for the increase in seizures, Mr Cutting said.

British officials believe the fact they have so far prevented large-scale, organized crime syndicates from being formed — unlike North America — is a chief reason the heroin for sale is so pure — as much as 90%.

It is only because addicts have switched to smoking or sniffing heroin that deaths from overdose, as well as deaths from hepatitis associated with using dirty syringes, have remained low.

Mr Cutting said at least 80% of the heroin seized in Britain is from the Indian subcontinent, particularly remote tribal areas in Pakistan where opium has been cultivated for long periods.

Mr Cutting: "Much of the problems come from these areas, which are virtually unpoliceable. Their drugs are the cheapest in the world and the street sales value has gone down because there is so much on the market.

"I pay the highest tribute to Pakistan for firmly recognizing the problem in the West, and for realizing it is also a domestic problem. They are making tremendous efforts to deal with it."

Mr Cutting said there is evidence that smugglers are trying to switch operations from Heathrow, but the agency is prepared to deal with this, and more investigators have been assigned to tracking down smugglers.

Ironically, increased heroin smuggling has resulted in less marijuana smuggling into Britain as Indian and Pakistani gangs handle both drugs and now find heroin much more profitable.

The amount of cocaine, morphone powder, and amphetamine powder seized by customs was down over 1981 figures but LSD seizures were up.

Smugglers jailed

LONDON — Most drug smugglers caught by British Customs and Excise Officers go to jail.

Figures released with the trafficking report from 1982 show that customs prosecuted 927 people for smuggling charges in 1982 and 905 of them were convicted. Sentences totalling 870 years were handed down by the courts.

Drug use is key in pain control

TORONTO — A mild overdose of drugs initially to treat a patient suffering from chronic pain is better than playing it safe, says the chairman of the department of pharmacy practice at the University of Utah.

Arthur Lipman, Pharm D, says a strong first dose is needed to ensure the patient's pain is removed. If the first dose doesn't work, the patient may become anxious thus increasing the person's perception of the severity of the pain.

A doctor will then have to use even higher doses of the drug to overcome the problem, he said here at the Ontario Hospital Association conference.

It's also important that the second dose is given before the effects of the first one wear off, Dr Lipman says. Chronic pain includes the pain the patient remembers, the current pain, and the anticipated pain.

"Therefore, if you only treat the current pain you've failed," he says.

One of the more important factors in the successful treatment of pain is to involve the patient in the therapy, Dr Lipman adds. Patients have to help determine what are their best dose levels, and that cooperation won't occur until a patient is "out of the pain."

Dr Lipman advises using relatively few drugs to battle pain but using them aggressively. Drug therapy is the "cornerstone of pain control" and will continue to be because it's cheap and it's easy to measure its success.

However, doctors' attitudes in the therapy are also important.

"You (the conference delegates) can do a lot to make a lot more people comfortable."

GILBERT

'. . . there is a rich field of enquiry here . . .'

Caffeine and myopia

By Richard Gilbert

"Coffee (which makes the politician wise, and see through all things with his half-shut eyes)"

Alexander Pope
The Rape of the Lock
1712-1714

The strains and uncertainties of political life drive some politicians to drink and others to despair. So far, the only occupational disease I have incurred is (literal) nearsightedness. During my second year on Toronto City Council I began sitting nearer the television, choosing seats closer to the cinema screen, and wondering why the faces of my adversaries across the council chamber were becoming so featureless.

When bicycle riding became hazardous I had my eyes examined, and was told I should wear spectacles to correct the moderate myopia that the tests confirmed. I was so pleased at being able to see the distant world again, I thought little about the causes of my new disability beyond being mildly curious as to why I had become myopic in my late thirties rather than in my teens.

The ophthalmologist seemed even less curious than I was about the late development of the disability. I let the matter rest with an aside about how my eyes had survived decades of intense academic work only to be defeated by the mounds of paper that now crossed my desk at City Hall.

Differing views

One day in December, Abe Kirschner, a Montreal optometrist, arrived at my office and set me thinking about myopia. Dr Kirschner is a real live wire, with strong interests in many areas including diet and, of course, eyesight. He came to see me to discuss the results of a study he had conducted with a Dr Schmid of Concordia University on "The effects of low-powered plus spheres and caffeine intake on the reading habits of university students."

Before explaining the Kirschner and Schmid study, it is necessary to explain a little bit of optometric theory and note the differing views about myopia held by optometrists and ophthalmologists.

Optometrists describe themselves as specialists in the detection and treatment of eye disorders, treatment being achieved chiefly through the prescription of corrective lenses. Ophthalmologists (also known as oculists) do the same thing but being medically licensed they can also administer drugs and conduct surgery. 'Optometry' has its roots in the Greek words for vision and measuring. 'Ophthalmology' comes from the Greek words for eye and speech.

Optometrists tend to believe that at least some myopia is preventable or curable by the judicious use of well-prescribed lenses. Ophthalmologists, on the other hand, while recognizing, of course, that lenses may compensate for myopia, tend to believe that the disorder is a matter of genetic fate.

Thus Scheie and Albert's well-used *Textbook of Ophthalmology* says the following: "Some authorities have attributed myopia to the close use of the eyes during school age, but there is no good evidence that the close use of the eyes changes the degree of myopia in any way." The text adds, "some ophthalmologists believe that correction by spectacles prevents further progress of myopia. This probably is not true."

The thrust of Kirschner and Schmid's work was to examine, using a double-blind design, the effect of a plus (ie, converging) lens on reading speeds. This is the kind of lens that is used to compensate for farsightedness.

Of the 41 student subjects, 26 showed some kind of improvement in reading speed with the lens. The other 15 subjects read less quickly. The mildly converging lens has the effect of magnifying text. In reading such magnified text the eye is effectively focusing at a more distant point than would be the case if the text were not magnified. Consequently, the ciliary muscles, which bulge the eye's lens in order to achieve the greater refraction required for near focusing, are doing less work and the eye seems less strained.

I tried the plus lens myself. I was able to read more quickly with the lens, and my eyes felt more relaxed with it.

The 26 students who improved (average improvement was 24 words per minute) were lent a pair of glasses with the plus lens for three weeks. At the end of this period all reported easier reading. Some reported that they did not have to reread as often for meaning. Some said they suffered eyestrain without the lens but not with it. On examination, three previously myopic students exhibited less myopia after the experience with the plus lens.

Caffeine effect

The 15 subjects whose reading speed was lower with the lens (average decline was 34 words per minute) did not differ significantly from the other subjects in terms of age or degree of myopia. They did differ in terms of coffee consumption, information about which Dr Kirschner had collected as a result of his general interest in nutrition. Only three of the subjects whose reading speed increased reported drinking coffee equivalent to 1,800 milligrams or more caffeine a week (ie, about three or more cups a day). Only one of the subjects whose reading speed decreased reported drinking coffee equivalent to 1,200 milligrams or less caffeine a week (ie, about two or fewer cups of coffee a day).

So, if this work can be replicated with proper controls, we would know that people can improve their reading speed with weak magnifying lenses if they don't drink too much coffee. What does this have to do with squinting politicians?

Myopia occurs when the eye's lens is too strong for the length of the eyeball. Ideally, when the ciliary muscles are relaxed the eye's lens forms an image of a distant object on the retina. At least three things can change to cause the image to be focused in front of the retina, as it is in myopia: (i) the lens can grow stronger, without a compensatory shortening of the eyeball; (ii) the eyeball can lengthen, without compensating relaxation of the lens; and (iii) as in some diabetics, the fluid between the lens and the eyeball can change in consistency, in effect making the lens stronger. The result in any of these cases is that the image is blurred. The sufferer sometimes squints because a narrow opening between the lids helps to sharpen the image.

Dr Kirschner believes that much myopia is caused by close work, although he concedes that evidence on this point is inconclusive. Focusing a near object on the retina requires tension in the ciliary muscles, which 'bulge' the lenses making them stronger refractors and thus able to bring forward to the retina an image that would otherwise fall behind it. Prolonged close work, says Dr Kirschner, can do two things. It can cause spasm or locking of the ciliary muscles. It can also cause stretching of the eyeball on account of pressure from the bulged lens. Either might be permanent. Either might be at least partially prevented by the judicious use of a plus lens during development of myopia.

Caffeine could work, according to Dr Kirschner, by compounding the tensioning of the ciliary muscles during close work and thereby making it more likely that myopia-causing locking and stretching will occur. In his own study, he argues, the moderate and heavy coffee drinkers could not benefit from the plus lens because the caffeine in their bodies maintained ciliary muscle tension that would otherwise have been lost on account of the plus lens.

If Dr Kirschner is right, my myopia may have been caused by all the close work I was doing (and still do) combined with the tensions of political work and occasional departures from the two-cup norm that I try to adhere to for my coffee consumption, departures induced by thirst during interminable meetings where coffee was the only liquid available.

Meat needed

His suggestions about the causes of myopia and the involvement of caffeine require a lot more meat on them before they can be taken seriously. Nevertheless, they are intriguing because they speak to a possible link between our society's most prevalent treated disorder, myopia, and our most popular drug, caffeine. I became convinced that there is a rich field of enquiry here, neglected both by ophthalmologists, who seem to have made up their minds about myopia many years ago, and by optometrists, who seem short on research tools to test their intuitively sensible notions about how it is that half of us do not see very well.

NEWS

Stiffer DWI penalities could overcrowd jails with senior citizens

By Mark Kearney

TORONTO — The move toward stiffer penalties for drunk driving could mean more senior citizens spending time in jail, says a Massachusetts gerontologist.

Allan Meyers, PhD, of the Boston University School of Public Health, says that in Maine, where the law has been made tougher, some jails have become overcrowded with the elderly, the handicapped, and more women, in addition to the usual offenders.

If society wants more severe penalties it must be prepared to accept these new types of criminals in jails, he said at the American Society of Criminology annual meeting here.

"Maybe that's how you stop drunk driving," Dr Meyers says, but it could lead to a reaction from some people who oppose putting an old person or someone with a disability or medical condition in jail.

Increased jail sentences will also be more costly, he told **The Journal**, but that has to be weighed against the possible cost of human life if drunk drivers, no matter what age, aren't punished.

In the United States, federal funds are provided to states which introduce mandatory penalties for drunk driving, Dr Meyers says (**The Journal**, Nov, 1982). That can mean stricter enforcement and increased use of jails.

Nevertheless, statistics show that while there has been an increase in the population more than 55-years-old in recent years, the levels of alcohol-related crime among that group have declined, he says.

However, "the data also show that alcohol-related crime currently accounts for the great majority of reported crime by older people. In 1978, when alcohol-related offences accounted for 17% of all arrests, they accounted for 58% of arrests of people aged 55 or older, more than three times higher than among the population at large."

Dr Meyers adds that driving while impaired is the most common offence among older people — about 20% to 25% of all arrests — and about twice the proportion of all arrests of other age groups.

He says he can't explain that statistic, but it's possible older people are healthier, more prosperous, and drive more than in the past.

Alcohol related crimes account for the great majority of crime by older people

Alcohol is pushing out Rx misuse as concern of elderly: Mich study

MONTREAL — Prevention and education programs on alcoholism need to expand and include the elderly, says Sandra Peltz, MSW, of Bi-County Hospital in Warren, Michigan.

Alcohol problems have recently surfaced as the critical treatment concern of the elderly in four of five areas in Michigan that have provided services for aging and substance abuse, she says. In the first year of the program, started in 1979, medication misuse and abuse were the major concerns.

However, the focus has shifted to alcohol problems and "service expectations were narrowed to outreach/casefinding and outpatient treatment," Ms Peltz said here at the American Public Health Association's annual meeting.

This may continue to be a growing problem among the elderly as the proportion of older people increases in the general population, she says. However, her project data show older people are more likely to remain in treatment, and the rate of success is at least as good as, if not better than, for younger people.

Ms Peltz also noted that the data show alcohol problems in older women appear to be as common as those among older men, if less visible. A triple stigma exists for the female client: being a woman, being older, and being an alcoholic.

Ottawa sets '84 deadline for drug 'security packs'

OTTAWA — Regulations ensuring that "security packages" are used for non-prescription drugs will come into effect Jan 1, 1984, says Health and Welfare Canada.

But a pharmaceutical industry spokesman says many companies already have the packaging, and others are in the process of introducing it.

Gordon Postlewaite, director of communications for the Pharmaceutical Manufacturers' Association of Canada, says industry has worked closely with government in the past three months to establish guidelines for security packaging. He says he doesn't foresee any problems in meeting the government's deadline.

Representatives of the drug industry set up a working party with the federal health department last year following the Tylenol deaths in the United States.

Capsules of Extra-Strength Tylenol — a big-selling headache remedy — were spiked with cyanide and resulted in seven deaths in the Chicago area.

Mr Postlewaite told **The Journal** the government regulations will probably be based largely on a report submitted by the working party. It suggests products that should be in tamper-proof containers include all drugs for ingestion, inhalation, and insertion, and for application to the eyes.

A variety of security packaging methods will be acceptable and labels may be added to alert the consumer to the security feature on the package that should be untouched at the time of purchase.

The regulations will be broad and all-encompassing, but legislation can't guarantee absolute security, he says.

"What you need is an informed consumer and a cautious consumer," Mr Postlewaite says, and that involves educating them about how to recognize whether a package has been tampered with.

The deadline has been set for next year to allow consumer and industry groups to comment on the proposed regulations and to permit companies time to use up existing stock, he added.

Child poisonings not always accidental

TORONTO — Supposedly accidental child poisonings are not always accidental, says a study by Cincinnati doctors.

"Child abuse by poisoning is common and requires a high index of suspicion as do cases of abuse by battering," say Drs Mark Dine and Mark McGovern of the Children's Hospital Medical Centre in Cincinnati.

Drugs and alcohol are among the substances used by parents who deliberately poison their children, the study says.

In several cases, a child has been given a dose of a drug the parent was taking, including Valium and other tranquillizers, reports *Medical News*, (Dec 2, 1982). In some cases, the children were brought to hospital emergency rooms by their parents, who claimed the poisoning was accidental.

Of the 48 cases of child poisoning studied, eight were fatal, and one resulted in permanent brain damage. Thirty percent involved continuous administration of the poisonous substance to the child. In 20%, poisonous abuse was combined with battering. The children ranged in age from 19 days to 10 years.

DWIs nabbed once in 1000 trips

By Mark Kearney

TORONTO — Stiffer penalties for drunk driving won't solve the problem in the long run, says a professor of sociology at the State University of New York at Buffalo.

H. Laurence Ross, PhD, and author of *Deterring the Drinking Driver*, says studies throughout the world show that severe punishment only seems to deter people for a short time.

Once they realize their chances of being caught and convicted are small, they usually return to their regular drinking and driving habits, he said at a lecture at the Addiction Research Foundation here. The chances of being caught are about one in 1,000 driving trips.

Thus, campaigns such as Mothers Against Drunk Driving (MADD) may not work, he says. There is a movement in the United States by MADD and others to impose jail sentences for drunk drivers.

However, many drivers, especially those who weren't involved in an accident where anyone was hurt, are less likely to be convicted when the penalty is that serious, Dr Ross says.

Possible solutions to reduce injuries and deaths from drinking and driving include raising the drinking age, lowering the availability of alcohol in society, making cars and roads safer by removing obstructions from the side of the highway, and introducing safety measures such as air bags and seat belt laws.

"It's worth trying all kinds of counter-measures," he says.

Officials would also have to raise people's perception of the likelihood of being caught for drinking and driving, he adds. This might mean establishing many more roadside breath analysis tests, to ensure that people realize there is a good chance of being stopped by police.

Dr Ross says introduction of blood-alcohol content laws and random police crackdowns on drinking drivers only seem to have short term effects. The more publicity and discussion a new law generates the greater effect it has, he says.

EAP variables should be linked

By Harvey McConnell

PHILADELPHIA — The employee assistance program (EAP) field is still young enough that the many variables can be linked in a coherent manner.

"But if we do not start to try and tie some of these things together to see what kind of relationships exist, it is very likely to run away from us," believes Dan Molloy, program director for the United States National Maritime Union, which represents unlicenced seamen.

Mr Molloy was speaking here to the annual conference of the Association of Labor Management Administrators and Consultants on Alcoholism (ALMACA). He said EAPs cover an enormous range of variables: occupational alcoholism programs, employee assistance programs, the wellness model, supervisor model, medical wellness model, behavioral model, mental health model, professional model for professionals, labor program, management program, administrators' program, task force, advisory committee, policy.

"I probably mean something different with each of these concepts than you mean," he added. Research on relationships among the variables has to happen, but is not really going on now, he said.

Mr Molloy said it is useful for directors of a particular program to be able to measure themselves against similar programs in a non-competitive way, just to see how well they are doing. His union was one of the members of the now-defunct — because of budget cuts — national alcoholism program inventory system run by the US National Institute on Alcohol Abuse and Alcoholism. They were able to compare their work with 11 other programs, known only to the institute, to judge their progress.

Mr Molloy noted research is expensive and, in future, most information will be fed into computers for analysis and distribution.

He said different jobs require different approaches to employees with drinking problems.

In the National Maritime Union, for example, the system is supervisory referral. The hitch is that the supervisors are the licenced members of the crew, and their separate union does not have any occupational programs.

Mr Molloy said one question those in the EAP field should be asking now is what can be done for the unemployed worker. Should an organization's EAP continue to work with a man or woman now unemployed?

FEATURES

A 10-year dream in jeopardy

Whither career teaching in substance abuse?

By Betty Lou Lee

OAKLAND, CA — The Career Teacher Program, begun 10 years ago with the aim of training a career teacher in substance abuse in every United States medical, osteopathic, and public health school, faces an uncertain future.

About 60 such teachers have been trained through the program, but its continued funding by the federal administration, through the US National Institute on Drug Abuse (NIDA) and the US National Institute on Alcohol Abuse and Alcoholism (NIAAA), is in doubt.

Charles Buchwald, PhD, director of the Career Teacher Training Center at the State University of New York Downstate Medical Center, Brooklyn, was coordinator of An International Perspective on Substance Abuse held by the Association for Medical Education and Research in Substance Abuse (AMERSA) and the World Health Organization. Education of health professionals was a major theme.

"When the current administration took office, there was a marked de-emphasis on anything called training . . . absolute prohibition might be a better term than de-emphasis," he said at a discussion group session.

"Our program may become a casualty. Many other programs have managed to save themselves by adopting new names and new guises, but as yet we've been unable to develop a correct mechanism for doing that.

"The current mandate is for research; education is frowned on, and training is a really bad word. The training division of the NIDA has become the technology transfer division."

The original plan was to have six training centres, but it never got beyond two, and Downstate is now the only one, he said.

AMERSA was an outgrowth of the program, first as an association of those teachers in 1976, and later including other faculty members who are educators and/or researchers in substance abuse. There are now 220 members from more than 90 medical schools.

Niven: exploring other ways

AMERSA president Robert G. Niven, MD, professor of psychiatry at the Mayo Clinic, was only slightly less pessimistic than Dr Buchwald in remarks at the conference's closing session, and in a later interview with **The Journal**.

"The future of substance use is assured . . . it will outlive all of us. The future of substance abuse is also assured. The future of drug abuse education is perhaps not so well assured.

"I think the career teacher grants are in a lot of jeopardy because the decision has been made that training, including ours, is of lesser priority than other things.

"I think it's been a remarkable program. It's beginning to be duplicated or copied in other kinds of areas . . . and we like to think at least it's not completely certain it will be cut. We're continuing our lobbying efforts."

As for AMERSA itself, "the staff and administrative support of the organization, which is an important part of it, comes out of the career teacher training centre grant to Downstate, so if that grant is cut, and the centre is cut, then we will be in difficulty and will have to do some other things to keep the organization going.

"I don't think there's any question the organization will survive, it's a question of how and what we'll be able to do. The people are very devoted. We're actively exploring other ways of getting funding. We have several options, from raising dues (now $30) to getting another grant."

AMERSA's work includes an annual conference on medical education in substance abuse (this was its first international meeting), educational materials, maintenance of a speakers and consultants bureau of members, and a national network of field placements for students in the abuse field.

While two government speakers at the meeting talked about educational roles for the health professions, neither referred directly to the career teacher program.

Carlton E. Turner, PhD, director of the White House office on Drug Abuse Policy, didn't contradict a questioner from the audience who said the program "has just been defunded."

Dr Turner suggested that since a survey of state governors showed they considered substance abuse among the top three problems, "If you go to them, there's a distinct possibility you may get more career teacher slots than you have now."

Asked later about that approach, AMERSA president Dr Niven said, "that's one possibility, but I don't think it's terribly viable. I would be surprised if we got more than one or two that you could talk into that, seeing there are such demands for that money (block grants from the federal government)."

William Mayer, MD, administrator of the Alcohol, Drug Abuse, and Mental Health Administration, said the role of doctors in changing attitudes to alcohol and drug abuse among students starting out in medicine "is more important than anything we can do."

He suggested discussion about establishing a sub-specialty in medicine. "I see you establishing a kind of a new profession, with its own language, its own body of literature, its own place in the health care professional spectrum."

A number of speakers throughout the week asked whether it was preferable to establish a specific course in substance abuse during professional training, or incorporate it in other courses, such as psychiatry, obstetrics, pharmacology, and internal medicine.

Turner: go to your governor

Betty Lou Lee reports from the AMERSA/WHO conference: An International Perspective on Substance Abuse.

There was no consensus, nor was one to be expected among 200 people from 15 countries where facilities, resources, personnel, cultural influences, and attitudes are so diverse.

Frequent references were made to the resistance among those who control curricula to add additional material, especially about something which some health professionals still feel isn't a medical problem.

In other health professions, such as nursing and physicians' assistants, there may be even fewer opportunities for abuse education than in medicine.

Criticism of the attitudes of many clinicians to substance abusers was common, but none was as graphic as that of Marcus Grant, PhD, of the Alcohol Education Centre in London:

"In England, health professionals have a very poor view of alcohol and drug dependent patients. They see them as people who will make outrageous demands on the clinician's time, mess up the waiting area, tear the magazines, pee on the carpet, punch the receptionist in the nose, and turn out to be wholly objectionable."

In Yugoslavia, care of alcoholics starts at home

By Betty Lou Lee

OAKLAND, CA — To Vladimir Hudolin, the therapeutic community for an alcoholic is the entire environment — family, neighborhood, and workplace.

Dr Hudolin has been a driving force in development of treatment and prevention programs for 30 years in Yugoslavia, and particularly the Republic of Croatia, where he is director of research at the University of Zagreb.

Croatia has 120 counties, with 4,000 local communities, and it is at this level that programs are now organized, he told an international conference on substance abuse held by the Association for Medical Education and Research in Substance Abuse (AMERSA) and the World Health Organization.

"We now start treatment on an outpatient basis in the factory or the community . . . Instead of a clear-cut medical model, we encompass a medical-social model," Dr Hudolin said.

All the social and political forces are organized around the primary health care team, which can include nurses, psychologists, social workers, and sometimes priests, "who can do an important job after they are trained and educated." Dr Hudolin said doctors are the hardest professionals to get involved in the treatment of alcoholism, and psychiatrists are hardest of all.

Instead of patients and their families going to a centre, staff go to them in the community.

Dr Hudolin received the third annual AMERSA award at the meeting for his contribution to medical education and research in substance abuse.

In 1964, he established the department of psychiatry, neurology, alcoholism, and drug dependencies at the University of Zagreb. He is noted for his multiphasic alcoholism treatment concept, and for setting up Clubs of Treated Alcoholics, similar to Alcoholics Anonymous.

He is honorary president and chairman of the International Association of Social Psychiatry, and president of the Mediterranean Association of Social Psychiatry.

In the mid-60s, he began a register of all alcoholics treated as inpatients within Croatia, and there are now more than 100,000 in the register. He estimates that 15% of adult males are alcoholics, and an equal number are excessive drinkers.

Wine and strong brandies are favorite drinks, and "there are nearly no abstainers." One of the national myths about drinking is that Mediterranean people "know how to drink" and it doesn't bring them to alcoholism.

There was a moralistic attitude toward alcoholism until the Second World War. Then, opinion was influenced by the Russian attitude that alcoholism was "a social problem that would be resolved by socialism."

Hudolin: alcoholism cannot be isolated from mental health

Then came the medical model, but many general practitioners paid lip service to it, Dr Hudolin said. A study of doctors' attitudes showed they related positively to schizophrenic and neurotic patients, but negatively to alcoholics, drug addicts, and criminals, attributing to them adjectives like distasteful, unsensitive, unimportant, unthankful, ugly, and false.

In 1954, the Red Cross took over the alcoholism program, and Dr Hudolin took over the organization of programs for Croatia about 10 years later.

He believes that a patient must be motivated to seek treatment: "Compulsion is out of the question," and alcoholism can be treated "only with full abstinence."

Although there was heavy drinking in Yugoslavia a century ago, there were few reports of alcoholics, and he believes a shorter life span may have been the answer. "If they live long enough, I think all moderate drinkers become alcoholic."

Of the 100,000 people in the register, 66,560 are employed. "Once they are diagnosed, they cannot be fired. They are protected because they are sick," he noted.

The ratio of male to female alcoholics changed from 8:1 to 5:1 between 1965 and 1979.

During those same years, 74,021 patients accounted for 129,188 hospitalizations totalling 5,141,895 hospital days in Croatia. During the same years, 78 women and 1,747 men on the register died in hospitals, and he noted they had a higher rate of malignant disease than the general population.

A sharp drop in alcoholic psychosis in 1979 might be one of the positive results of the treatment program, he said.

"Overall results in treatment are very good, but there is also a question of controlling alcohol-related problems . . . We think alcoholism cannot be isolated from the rest of mental health."

He also believes a trend to older average age of patients admitted to hospital is an effect of the community-based programs. "The younger ones are now treated as outpatients, and only the older, more difficult patients are admitted."

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Letters to the Editor... Letters

Universal approach to recovery at West Coast women's centre

I read with interest the article, Treatment centre for women only concentrates on wellbeing, lifestyle (**The Journal**, Nov 1982). The article began by announcing that Canada's second addiction treatment program for women had just opened. The centre is named Aurora: Community Women's Alcohol and Drug Treatment Program.

We are always pleased to hear about more treatment facilities for women, but, we were very interested in this program as we are an intensive-treatment, residential facility for women with alcoholism/addiction. We have been in business since 1972 and our name is Aurora Society. We are funded by Alcohol and Drug Programs, British Columbia ministry of health.

We offer a wholistic approach to recovery with a feminist perspective. We believe recovery is a physical, emotional, and spiritual concern. In dealing with the physical, we offer a chemical-free program and philosophy. We teach our clients about nutrition and, particularly, the importance of managing blood sugar levels. We withdraw women from caffeine and sugar as much as possible. This gives them a chance to experience a stable, physical condition. In this process, they have a chance to see and experience just how much these chemicals affect their physical and/or emotional wellbeing

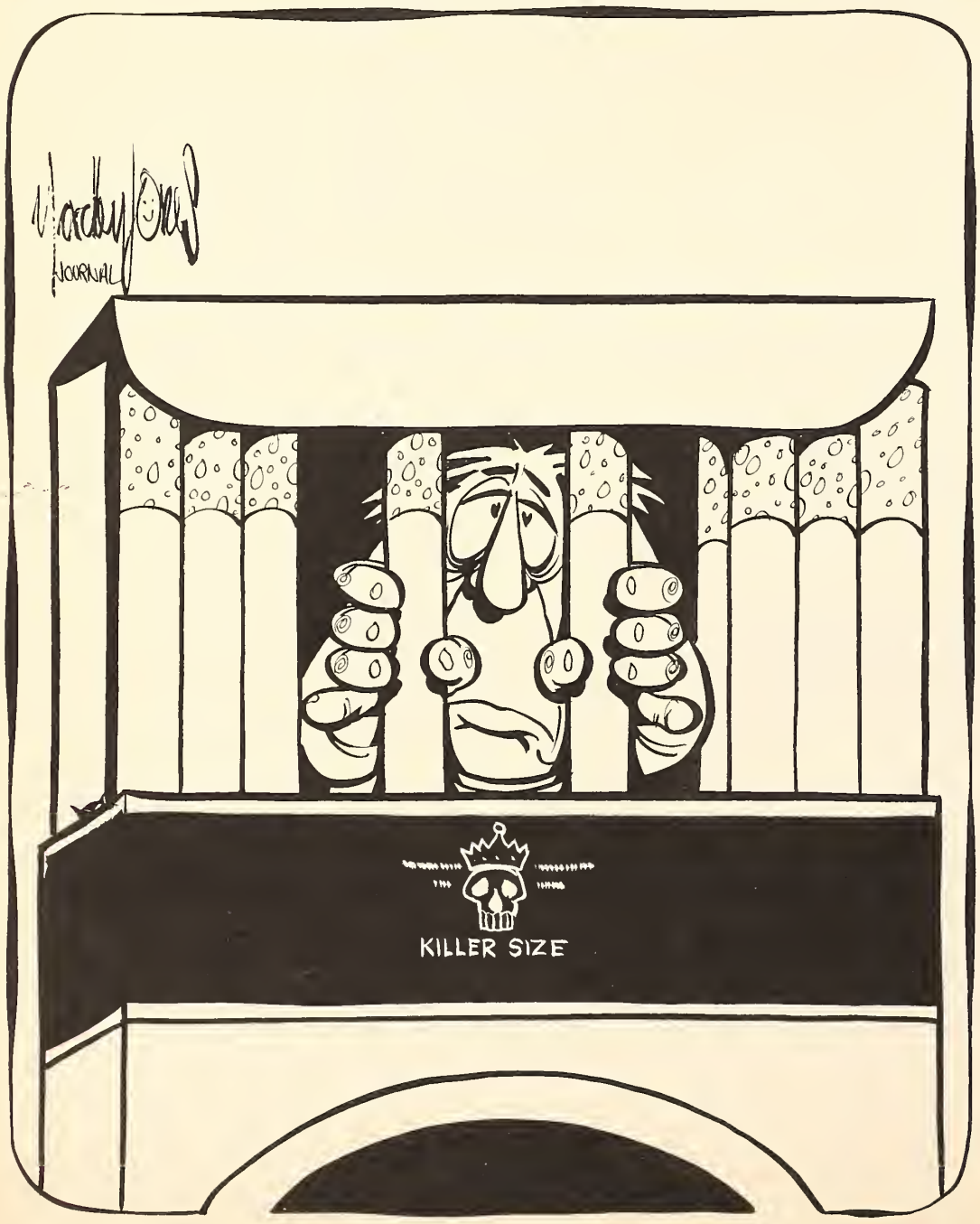
In our individual counselling and group work, we deal with all the issues which have been part of the woman's life experiences. Along with all the "standard" treatment issues, we have discovered the need to become quite skilled at dealing with issues of incest, sexual abuse, battering, and sexual functioning. We strive to be able to guide our clients through to a place of accepting their lives without drugs. To do this, we must be able to help them look at the abuse of which they were victims, as well as at ways they have abused others. We also do family counselling.

We believe in and utilize AA (Alcoholics Anonymous), NA (Narcotics Anonymous), Al-Anon, and Women for Sobriety. Vancouver is fortunate to have a good network of out-patient counselling services for ongoing support after the six-week treatment program.

Aurora Society is now sponsoring an hour-long film about women's recovery called Turnaround. We believe this is a very special film that breaks down stereotypes, motivates women in treatment, and, we hope, motivates women *into* treatment.

The National Film Board of Canada has given us substantial financial backing. However, we are still trying to raise sufficient money to finish this project. Donations of any size (to Aurora Society-Film Project, 2036 West 13th Avenue, Vancouver, BC V6J 2H7) are tax deductable.

Sherry Mills
Executive director
The Aurora Society
Vancouver



Science/journalism link — topic needs to be aired

I think the last paragraph of Richard Gilbert's column, Science and journalism, (**The Journal**, Dec 1982) is much too modest. "Science and journalism" is a topic I ponder almost every day, and I found the column very "insightful." This is a subject that needs to be aired.

Recently I found myself the sole representative of "the lay press" at a three-day scientific conference. I wish Dr Gilbert had been there to help when I was put in the hot seat to defend the media. The major complaint was "sensationalism" — which Dr Gilbert dealt with, along with other complaints. I'm very glad he stressed the symbiotic relationship — and the overlooked similarities — between scientists and journalists.

Heard this quotation? (I can't remember the source): "Scientists are to science writers what laboratory mice are to scientists." Perhaps too inflammatory?

The column is now in my "science and media" file.

Looking forward to the next instalment.

Pat Ohlendorf
Toronto, Ontario

DWI laws can be changed

Citizen action pays off

An article by Betty Lou Lee, Renewed fervor fails to alter grim DWI picture, (**The Journal**, Oct 1982) is unduly pessimistic.

RID(Remove Intoxicated Drivers) supports mandatory licence suspension for 90 days for those failing the breath test, and random spot-checks so the public perceives there is a good chance of getting caught and that, when caught, real punishment (loss of licence) will result immediately and administratively.

Where this system is in place, fatalities have fallen from 45% to 59% almost right away. In Iowa, 79% of those arrested were first offenders, who usually do not suffer licence suspension in the United States. They are given a conditional, or work licence. Positive data on decreases in fatalities and alcohol-related accidents and injuries are reported in Minneapolis (59% drop in fatalities), Iowa (51%), and West Virginia, District of Columbia, and Montgomery, Maryland (51%).

In New York state, loophole closing laws revoke licences for six months for refusing the test, and STOP-DWI committees have been established in every county which has RID members. Fatalities dropped 25% in the first quarter of 1982. We don't have administrative licence suspension for failing the test, however.

I believe we know what to do about the drunk driver: Take the licence immediately with no conditions and set up random checkpoints at dangerous places in our communities to catch offenders before they kill someone. The solution is not technological, it is political.

In New York state, drinking patterns and customs are changing quickly. Last New Year's Eve (1981) 400 people took cabs home from parties in the capitol area of Albany and Troy. Beer sales in bars have dropped 15%. Young people are thinking before they have those last five for the road. Bars are hustling to provide shuttle bus services from home to bar and return for $1, and people are using the service. Some bars are voluntarily closing at 2 am rather than 4 am, as they can legally do, for lack of patrons.

The missing link in most communities is the citizen activist group. New York state has 28 such RID chapters and was the first to reform its laws and policies to control drunk drivers. Another 102 chapters and groups cover 30 states, with some abroad. In time, there will be such groups in every county, in every state. Then the roads will be safer than before, and that time is very close at hand.

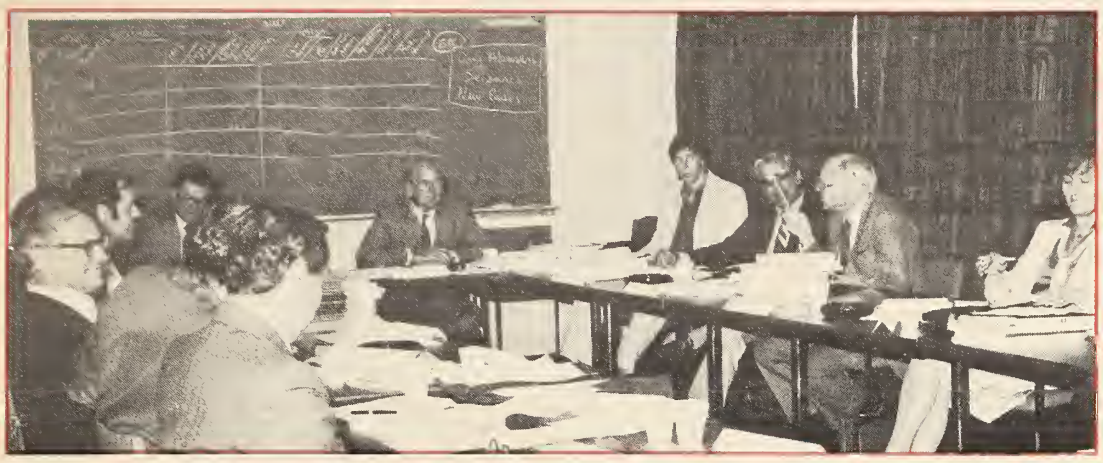
Doris Aiken
President RID-USA
Schenetady, NY

***The Journal* welcomes Letters to the Editor. Letters may be sent to the Editor, *The Journal*, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.**

FEATURE

Recommendations will go to United Nations

World drug treaty needs updating: experts



Working party: a triumph of international law, the treaty is taxed by technology

By Karin Maltby

TORONTO — The dramatic expansion of drug trafficking and abuse since the early 1960s has placed great strains on global mechanisms to control narcotics, international specialists in the field concur.

One of these mechanisms, enacted to amalgamate earlier drug control treaties, is the 1961 Single Convention on Narcotic Drugs.

While the Convention may represent a "triumph of international law," major changes in both world economics and technology have severely taxed the Convention's effectiveness, says Gene Haislip, director of Compliance and Regulatory Affairs for the United States Drug Enforcement Administration.

Mr Haislip was a participant in a "working group" meeting held late last year at the Addiction Research Foundation (ARF) here. Other participants included drug experts from selected countries which had signed the 1961 Convention, as well as officials from international agencies: Peter Lee, Commissioner for Narcotics, Hong Kong; Dr Ramon de la Fuente, Director, Instituto Mexicano de Psiquiatria, Mexico; Professor Mohammad Rashid Chaudrey, Pakistan; Dr Federico Raul Jéri, Peru; Police Major General Pow Sarasin, Thailand; Eva Tongue (PhD), International Council on Alcohol and Addictions, Switzerland; Neil Donaldson, Jacques LeCavalier, and Donald Smith (PhD), Canada; Dr Bror Rexed, International Narcotics Control Board (INCB); Jean Paul Smith (PhD), US National Institute on Drug Abuse, Dr Awni Arif, World Health Organization; and H. David Archibald (Chairman), Reginald Smart (PhD), and Glenn Murray, ARF.

The group met to identify what impact the Convention has had in terms of new legislation and new controls on drug abuse since the Convention took effect on December 13, 1964; what effect this legislation has had on drug use and abuse at both national and international levels; and what the impact has been in terms of new treatment facilities for drug abusers.

The recommendations the working group formulated will be presented in final form this month to the meeting in Vienna of the United Nations Commission on Narcotic Drugs.

Reginald Smart, rapporteur for the working group, and director, program development research for the ARF, says that, in general, the Single Convention "represents an indirect method of control which depends upon the willingness of national governments to comply with its requirements."

Much of the Convention, says Dr Smart, is concerned with recommendations rather than firm requirements.

"There is virtually no provision for penalties for breaking the rules of the Convention, other than public censure. International control, hence, depends on the various steps taken by national governments to act in accordance with the Convention."

Dr Smart adds that in some countries the Convention has led to the introduction of other controls — such as mandatory penalties for users, reductions in supply through crop replacement, or limitations on importing or diversion from legal sources.

Haislip

LeCavalier

"However, in many countries, there seems to have been little impact on national legislation. In some cases, this occurred because good legislation was already in place, but, in others, an expected impact has simply not occurred," Dr Smart told the 33rd International Congress on Alcoholism and Drug Dependence last fall in Tangier.

The Convention has also become outdated, he says. "Not long after it came into force, concerns about psychotropic drugs, such as speed, LSD, and THC were expressed in many countries. None of these drugs is covered by the Single Convention," a situation which led to the creation of a new treaty for psychotropics (**The Journal**, July, Feb, 1981), the 1971 Convention on Psychotropic Substances, which came into effect in 1976.

The Toronto working group debated extensively about, and finally recommended against, any fundamental changes in the treaty system which would see the Single Convention on Narcotics and the Convention on Psychotropics merged.

Dr Smart: "In the future we can expect to see the two treaties integregated," but a new treaty would not be seen for 10 to 15 years, and would be difficult for nations to agree upon.

Mr LeCavalier reiterated that the melding of two treaties "should be retained as a long-term objective, but, in the medium-term, the present Convention should be streamlined."

Dr Tongue, however, told the working group she is "a strong advocate of merging the conventions. We have reviewed the Single Convention trying to find fault . . . the only fault is that it is antiquated in view of the rapidly-changing drug scene."

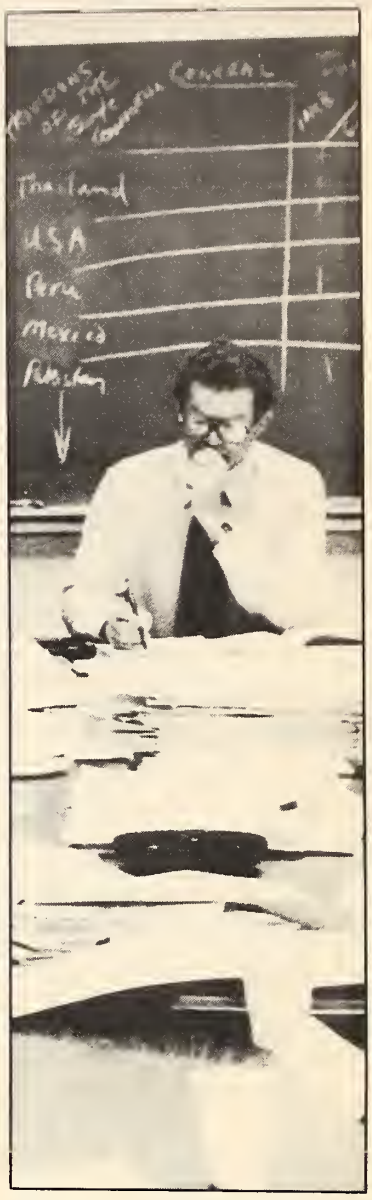
Recommendations are:

- The first, major recommendation is that governments develop a consensus on the basic issues where change in the Single Convention may be needed, and that they initiate the required studies to provide a more up-to-date and flexible international framework. The UN Commission on Narcotic Drugs, the group recommended, should assume the responsibility of ensuring that present and future issues, and future policy options, are identified systematically.

The importance of drug supply and demand reduction programs, at both the national and regional levels, combined with international collaboration, should be stressed. In addition, every effort should be made on behalf of relevant administrations and voluntary agencies to mobilize financial resources to increase support for "well-designed" action plans in supply- and demand-reduction programs on national, bi-lateral, regional, and international levels.

The UN Commission should review ways in which its monitoring and evaluation function can be more effective, the group recommended. And a research and monitoring function should be given more emphasis in the UN Division of Narcotic Drugs and the INCB (the International Narcotics Control Board).

- Increased attention should be given to the development of new and simpler ways to estimate legitimate future needs for opiates.
- The same controls that now apply to opium production and distribution should be applied to *Papaver bracteatum* (scarlet poppy, a rich source of thebaine, which can be used to produce narcotics, notably codeine), poppy straw, and concentrate of poppy straw, both of which are used for manufacture of pain killing drugs.
- Developing countries should be given technical assistance in policy development, training, drug distribution and prescription controls, crop substitution, basic health, and law enforcement.
- Countries should be encouraged to communicate the detection of suspicious vessels for interdiction of shipments on the high seas.
- Nations should enact laws providing for the seizure and forfeiture of monies and assets derived from the traffic in narcotics (**The Journal**, Dec 1982).
- Monitoring suspicious shipments of essential chemicals, such as acetic anhydride (used in processing heroin), and exchanging intelligence on them should be encouraged as a specific form of cooperation. In countries where chemicals are used principally for illicit purposes, national laws should be encouraged to impose restrictions.
- Crop substitution plans should be encouraged and be complemented by programs for eradication of illegal plantations. Where practical, direct eradication should be undertaken to curb expansion of illicit plantations (**The Journal**, Nov 1982).



Smart: an explosive increase in knowledge

International organizations and financial institutions should provide monetary support to assist those countries affected.

- National, regional, and international efforts to prevent and control the abuse of cocaine and coca paste should be increased. These issues should receive priority attention for international, multi-lateral, and bi-lateral programs, with emphasis on demand reduction.
- Parties to the Convention should investigate suspect drug orders and seek further information when the quantities of opiates requested are not consistent with the needs of the importing country. Importing countries should also investigate the genuineness of permit application.
- The UN Commission on Narcotic Drugs should request the UN Division of Narcotic Drugs to prepare an explanatory document on the treaty in all official languages.

Dr Smart: "Over the last decade, an explosive increase in knowledge has occurred. This includes genetic engineering, chemistry, and the neuro-sciences, as well as many new drugs, synthetic processes, and psychoactive chemicals. Some substances resulting from these developments do not fit easily into the existing conventions."

A final recommendation of the working group then, is that a group of experts be assembled to clarify the implications of these new developments for the field of drug abuse. As part of this, the group recommended a forecast of likely developments over the next 10 years.

NEWS

CODA calls for new 'act' to deal with cannabis

By Mark Kearney

TORONTO — The Council on Drug Abuse (CODA) has called on the federal government to transfer cannabis and its derivatives to a new act dealing with illegal drug use.

Fred Burford, CODA's new president, says this is "a moderate position" and the first time the council has formalized its beliefs on the issue.

A new act is needed because the current legislation under the Narcotic Control Act doesn't deal adequately with the problems of marijuana abuse, he told **The Journal**.

CODA has recommended the new law provide minimum penalties for all offences but no jail term for the first possession of a small amount of cannabis.

The council believes there should be no criminal record for possession, Mr Burford says.

A new act would also prevent absolute discharges for those charged with possession of cannabis. Mr Burford says such discharges are "laughable" to young people using marijuana and discouraging to police who may want to lay charges under the act.

Michael Harrison, CODA's executive vice-president, echoed remarks by Mr Burford about moving cannabis from the Narcotic Control Act to the Food and Drug Act. It could give people the idea marijuana is "pretty innocuous stuff," he said. That could prove dangerous because recent research on the effects of the drug show "there just isn't anything proper about marijuana."

Mr Harrison says the details of what would constitute "a small amount" of cannabis and the types of fines that would be set under the proposed act would be left up to legislators. He suggests a minimum fine of $100 and a maximum of $1,000.

CODA would also like to see absolute discharges replaced by community service orders or some equivalent, Mr Harrison says.

The council has also long recommended that any change in law be preceded by an objective and accurate public education campaign on the dangers of drug abuse. Mr Harrison says he's pleased the government is launching a three-year, $2.1 million drug education campaign (**The Journal**, Jan), but CODA wants to be sure the campaign pamphlets on cannabis contain clear and complete information about the dangers of drug abuse.

Mr Burford says he's encouraged by the government's campaign but "it has been baffling that a decision on this wasn't made years ago." However, the federal officials are making a "very sincere effort" to deal with the problem and the campaign should prove successful, he adds.

There's a 600-year history of legal opium use

Numbers, tradition stall treatment in Thailand

OAKLAND, CA — It's hard enough in any country to get addicts to accept medical treatment.

In Thailand, however, a physician is often one of the last people an opium or heroin addict will go to for help, since many Thais believe symptoms or problems are caused by evil spirits.

Other options would be a monk, fortune teller, or exorcist, who may pronounce a cure after three to five sessions. If the symptoms return, it's because a new evil has taken over, and it, too, must be exorcised.

Even if they do seek medical help, the country has 45 million people and only 6,500 qualified physicians. Of those, 1,500 are practising in the United States and don't want to go home, and another 3,000 are in Bangkok, leaving 2,000 for the 40-million people in less-populated areas.

And Thais dislike prolonged treatment or follow-up, whether for addiction, diabetes, or high blood pressure.

Superimposed on these drawbacks to treatment is a 600-year history of legal opium smoking, and the belief of many Thais that opium or heroin will improve strength, endurance, and sexual performance, and cure anything from stomach aches to cancer.

Many elderly people believe that if they suddenly stopped taking opium, they would die of a severe, bloody diarrhea (the Red Purge). In their closely knit families, children and grandchildren do anything they can to get them opium

Showanasai: the monk helps the patient save face

or heroin, and prevent them from seeking treatment.

The massive and multi-faceted problems in treating addiction in Thailand were explained to the International Perspective on Substance Abuse conference here by Aroon Showanasai, chairman of the department of neurology and psychiatry, Phra Mongkutklao Army General Hospital, Bangkok.

He is also president of the Psychiatric Association of Thailand, which has 150 members, only five of whom have an interest in treating addicts.

Traditionally, opium smoking was accepted by all levels of society, and the government collected taxes from the opium trade.

But in 1959, "without previous warning or preparation as to the consequences," opium smoking was declared illegal. Heroin started to flow in from Hong Kong, and the number of heroin addicts rose from 72,000 in 1959 to 200,000 in 1967.

Half the heroin is smoked, the other half injected intravenously, usually without antiseptic precautions.

Because of the extended, three-generation family, there are no skid rows for heroin or alcohol addicts. Forty per cent of heroin addicts work full time, and 30% part time.

Dr Showanasai said "nearly 100%" of Thais are superstitious, so even some physicians, scientists, and politicians will often first consult a Buddhist monk or fortune teller when they needed help.

"It may appear strange that such out-of-date practices were not reported before, but Thai people dare not say anything against the majority, and they see no good out of such reporting. Many of these scientists themselves are superstitious.

"Moreover, this treatment by the monk helps the psychiatric patient and their families to save face, by displacing all the blame to evil spirits who make them ill, not their own conflicts, etc."

While faculties of the seven medical schools are well aware of chemical dependence problems, the principal aim of these government-run schools is to produce enough general physicians to serve the rural areas. After internship, every doctor must spend two years in the provinces before residency training.

By the completion of internship, a doctor has had less than three months' training or education in all aspects of psychiatry, including drug abuse. He will work with addicts for one month in the third year of his residency.

Dr Showanasai said that while long-term treatment of addicts is impossible for now in his country, progress has been made in treating over-dose cases; 10 years ago, "they all died. We had no antagonists."

The ministry of public health has also organized training courses in substance abuse and its treatment for health professionals directly involved in such work, but there is still a shortage of personnel to take the courses. Some trainees attended courses at Ontario's Addiction Research Foundation's School for Addiction Studies in Toronto.

Governments still support Amethyst

TORONTO — There has been no withdrawal of support by the Ontario Ministry of Health to Amethyst Women's Addiction Centre, says Dorothy Loranger, program manager of the alcohol and drug abuse section of the ministry.

Ms Loranger was referring to a comment by Amethyst public relations officer, Sharon D'Arcy (**The Journal**, Nov 1982). Ms D'Arcy indicated government funding for the Ottawa-based centre had stopped, and the centre was having to turn to the private sector for support.

Ms Loranger, however, told **The Journal**: "Pending a review of the Amethyst application for 1983/84, it is the ministry's intention to make a similar amount ($40,000) available in the next fiscal year.

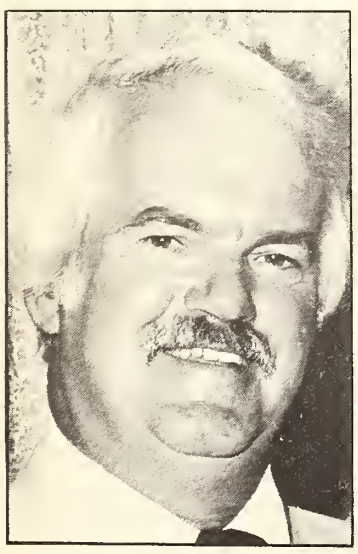
"The ministry has never shown a lack of interest in Amethyst. Originally the program was supported under a time-limited (three years) 'seed' funding mechanism. However, support has been continued on an ongoing basis in a show of active concern over the financial difficulties experienced by the program as federal research monies were terminating."

Ms D'Arcy says Amethyst has been funded by the federal and provincial governments since 1979, and, since 1982, by regional government as well. She says the federal grant has also been extended, on a reduced basis, to the end of January 1984.

"It is important to state that government funding has provided Amethyst the opportunity to establish a much needed service for women in the Ottawa-Carleton area," Ms D'Arcy says.

"However, we have been aware that Amethyst must diversify its funding base to include the private sector."

She says the letter from Ontario Health Minister Larry Grossman announcing the grant for 1982/83 "very clearly spoke to the fiscal period of 1982/83 only. His letter states that the expectations are that we will eventually become self-sufficient."



TORONTO — Edward Fitzpatrick was named president of the Canadian Addictions Foundation at the annual meeting here in December. Mr Fitzpatrick, of the Nova Scotia Commission on Drug Dependency, has been involved in education and rehabilitation services in the addictions field for 20 years.

Treatment programs for women 'a whole area EAPs neglect'

By Harvey McConnell

PHILADELPHIA — Company managements must set out a clear policy and suitable sanctions so their women workers with alcohol problems can be confronted and offered assistance.

At the same time, program personnel must learn how to deal with women, many of whom present at an early stage, and to refer them to treatment. For now, most women are not referred.

These are some of the findings of Mary Cahill, The Planners Studies, Newton, Ma, in a three-and-a-half year study. It involved 13,000 employees in 16 organizations in the public sector and light industry in the northeast United States. One-third of the workers were women.

Ms Cahill told the annual conference of ALMACA (Association of Labor Management Administrators and Consultants on Alcoholism) the major objective was to look at the way employee assistance programs (EAPs) and women employees react to each other. The team devised techniques and strategies to try and bring more women into programs.

They found, with a series of questionaires, that 17% of the women and between 20% and 29% of the men would be classed as problem drinkers, but fewer than 1% of the women and 4% of the men were in programs.

They were not able to investigate treatment programs for women as so few entered.

The researchers found that most male, first-line supervisors had a hard time dealing with women who had drinking problems.

"There are a lot of issues in the work place in terms of sexual harrassment and affirmative action for a male supervisor, who may be using these as excuses, not to sit down and confront a women whose work is inadequate at a certain time, or whose performance has deteriorated to the point where it is noticeable," Ms Cahill said.

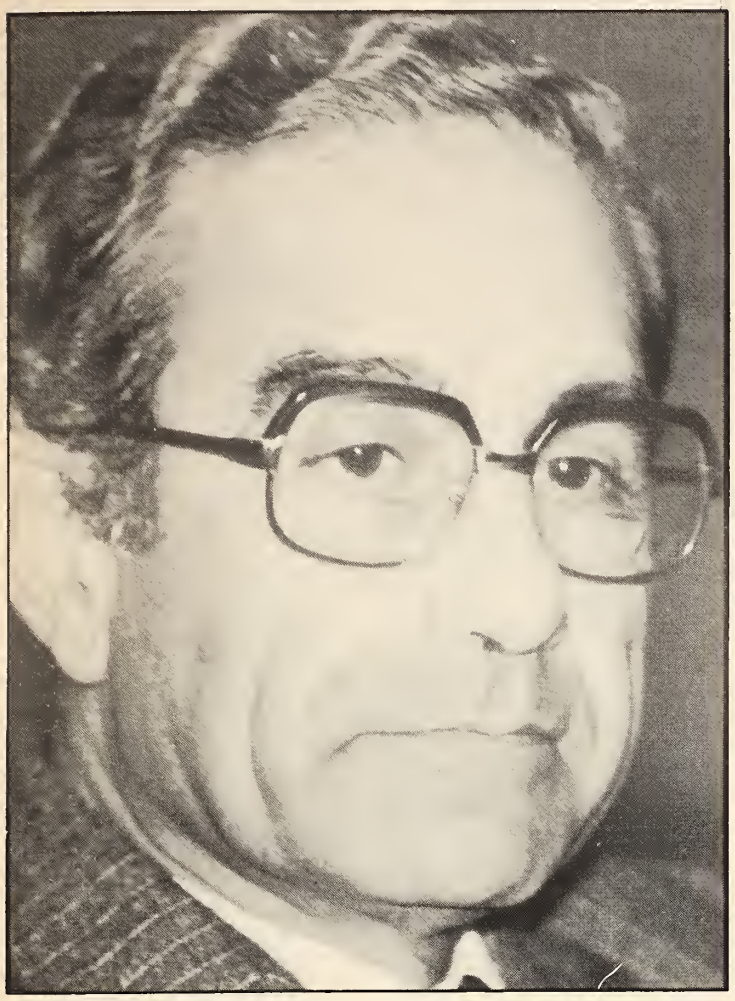
Managers were encouraged to set out precise criteria for a particular job done by women so their performance could be judged in the same way as for male employees. This will stop many women with alcohol problems from "slipping through the cracks."

Ms Cahill said if women did try to get into a program early in their drinking career, many people running the programs did not know how to deal with them. "We found only 20% of these women were being referred to treatment, even if they had indications that they had been binge drinking or that there was alcoholism within their family."

Ms Cahill said they found an "astronomical" 40% of the women and men workers said they had alcohol problems within their families.

She added: "This is a whole area EAPs neglect." General training of workers might include education on how to deal with alcoholism in their midst, because this certainly can affect job performance.

The team found the stigma of alcoholism is still strong among women workers — most of those who sought help were doing so outside the EAP program.



Soueif: the old code is changing, as new drinking habits appear

Egypt is trying Islamic law to cut entrenched drug use

By Betty Lou Lee

OAKLAND, CA — An attempt to apply the Islamic strictures on alcohol to opium is part of an experiment in treatment techniques in Egypt.

Some opium addicts are being told by religious instructors that the justification for the Koran's prohibition of alcohol is that alcohol is a psychoactive substance that interferes with good judgement. By the same criteria, taking opium is also a sin.

Mustafa L. Soueif, professor and chairman of the psychology department at Cairo University, outlined the experiment here at An International Perspective on Substance Abuse, sponsored by the Association for Medical Education and Research in Substance Abuse (AMERSA) and The World Health Organization (WHO).

Cannabis and opium have been used for centuries in Egypt, with rules for accepted use and conduct well defined, he said. The users are almost always male, with cannabis users outnumbering opium three-to-one. There is little use of heroin or morphine.

About 94% of the Egyptian population are Moslems.

"Opium is about the same as alcohol in the west," Dr Soueif told **The Journal**. "It is widely used, even by some clergymen."

While 85% of cannabis is smoked, opium rarely is. It is placed under the tongue, as a lozenge, or dissolved in hot drinks.

In the experimental, four-year study, now at the half-way point, 140 opium addicts are divided into a number of sub-groups. One half get group psychotherapy, which includes religious discussion, recreation, and attention to personal problems. In addition, they get either antidepressants, antidepressants and modified insulin, antidepressants and placebo, or placebo and insulin.

The other half of the study group gets one of these four modalities, but no group psychotherapy.

Dr Soueif said recent computer results show "at face value, the only treatment that seems to make any difference is group psychotherapy."

Dr Soueif serves as scientific consultant to the project, which is directed by Dr Gamal Azaim.

Alcohol is not a social problem yet in Egypt, Dr Soueif said. "It is sold legally, but socially it is not welcomed under quite a number of conditions."

Yet its use is on the rise among young people.

This is not the Egyptian counterpart of western youth in the 60s turning from their parents' drug of choice, alcohol, to others adults abhorred. Rather it is a case of youth emulating adults they see as setting new trends.

"There has been a radical change in Egyptian society with more modernization in the last three or four decades, and the rate of change is becoming faster," Dr Soueif said.

"The old code is breaking down, changing, with new habits of drinking making their appearance in certain circles and sectors, particularly those who get in contact with American and Western cultural influences, and who care to pretend they are being influenced by them.

"In some circles it is taken as a prestige symbol to make it clear you are Americanized or Europeanized. The change is beginning with adults changing their habits, and it is leaking to the kids."

Britain follows trend to tough DWI penalties

By Thomas Land

GENEVA — Britons convicted of drunk driving twice in the same decade will lose their licences for life.

Tough new measures to be introduced in March in Britain follow a trend established in Scandinavia and North America, intended to cut the high toll of drunk driving. Pressure is mounting in France, Italy, West Germany, and elsewhere to follow suit.

The United Nations' World Health Organization (WHO) here says alcohol-related problems — with "absenteeism, crime, and drunken driving foremost among them" — now rank among the world's major public health concerns. The WHO has recently expanded its capacity to respond to government requests for assistance in cooperative, rehabilitation programs.

A report issued by the WHO identifies the increased availability of alcohol as chief among the multitude of socio-economic factors that has led to a global rise in alcoholism, and impaired driving as one of the most serious alcohol-related problems.

The organization puts the medical, psychiatric, and social cost of alcoholism in North America alone at a conservatively estimated $43 billion a year. Drunk drivers kill more than 25,000 people in Canada and the United States each year — about half of all those who die in motor vehicle accidents — and injure about 700,000 more.

The campaign to get tough with drunk drivers began in Scandinavia in the early 1970s, establishing a widening, long-term trend. Comprehensive road safety legislation, prescribing tough penalties (including prison sentences in many cases) as a deterrent to drunk driving, was introduced in Finland in 1972, leading to a 50% decline in local, traffic accident fatalities within a decade.

About 30 states in the US have recently passed laws against drunk driving. Further legislation is pending to jail offenders, suspend their driving licences, and perhaps impound their vehicles (**The Journal**, Nov 1982).

Similar pressure is mounting in Western Europe. Many influential organizations such as the West German Association Against Drunken Driving, the Touring Club de France, and the Automobile Club of Italy are campaigning for tough legislation in their countries, although so far with little immediate effect.

However, the European Parliament — which represents the 10 member-nations of the European Community including West Germany, France, and Italy — recently passed a resolution describing preventative action against alcoholism as an urgent international priority, and expressing concern over the high cost in terms of lives lost through drunk driving.

Britain's new transport rules may well strengthen the case of the European road-safety lobby. The indefinite suspension of the licences of persistent drunk drivers, to be enforced starting next month, is provided under existing legislation, although the provision has been kept in reserve. People seeking to reverse a life-ban will have to prove that they have reformed their drinking habits, possibly through the testimony of their doctors.

NZ squelching liquor ads as alcohol purchases soar

By Pat McCarthy

AUCKLAND, NZ — After a year in which the average New Zealand household spent more on alcohol than on fruit and vegetables, or on fuel and electricity, new restrictions on liquor advertising have come into force.

The new requirements will put an end to newspaper and magazine advertisements linking alcohol with sport, driving, and "potentially hazardous activities" like water sports.

The voluntary code of advertising practice was agreed on by the liquor industry, advertisers, and publishers. Cinemas have also agreed not to show alcohol advertisements with any film that is approved for general exhibition. Advertising of alcohol is already banned on radio and television.

A Labour Party member of parliament has said he will introduce a private member's bill this year aimed at banning all liquor advertising.

In 1981, according to the department of statistics, the average New Zealand household spent NZ$8.71 a week on alcohol, $7.80 on fruit and vegetables, and $6.80 on fuel and electricity. (NZ$1 equals Cdn $.78).

The average New Zealander over the age of 15 years drank 220 bottles (745 millilitres) of beer, 26 bottles of table wine, and 8.5 bottles of spirits.

The population of 3.1 million consumed 444.9 million litres of alcohol. In terms of absolute alcohol, 55% was in beer, 22.7% in wine, and 22.2% in spirits. For the first time, more pure alcohol was consumed in wine than in spirits.

First Israel alc study 'surprising,' heaviest drinkers are native-born

By Macabee Dean

JERUSALEM — The problem of alcoholism in Israel is on the rise.

A survey by the Israel Institute for Applied Research reveals that heavy drinking, drunkenness, and alcoholism combined are the fourth ranking health problem in Israel.

This is the first such study carried out here, and the results are startling. A few decades ago, heavy drinking was thought to be confined to immigrants who brought the habit with them. Native-born Israelis — like Jews anywhere in the Western world — were thought to avoid heavy drinking.

However, the survey shows that the largest group of heavy drinkers in the country today are in the 20- to 24-years age group, most of whom were born in Israel.

The survey says approximately 5%, or 100,000 adults age 20 or more, "get drunk every few months." Of these, 65,000 get drunk at least once a month, and of these 21,000 get drunk at least once a week.

Approximately 43,000 Israelis, or 2% of the adult population, drink hard liquor daily.

Phina Eldar, of the ministry of labor and social affairs, estimates there are at least 7,200 alcoholics in Israel, most of whom receive no care. However, 2,000 are under the supervision of the nine centres for the prevention and treatment of alcoholism sponsored by the ministry.

While the problem of alcoholism is evidently growing, it is still rare to see a drunken Israeli on the streets. Of the 883,000 reports given out by police in 1981 only 21 were for drunk driving.

Tokyo tackles increase in drug abuse, trafficking

TORONTO — Illicit drug trafficking in Tokyo in the first half of 1982 rose 44.4% over the same period in the previous year.

Tokyo Metropolitan Police Department (MPD) figures show 2,415 people were taken into custody between January and June, 1982. The police confiscated 11.8 kilograms of stimulants during this period worth an estimated $11 million.

The amount seized was almost three times more than the four kilograms taken by police in the first half of 1981.

The MPD also report a drop in the percentage of organized criminals questioned in connection with trafficking and abuse because of the dramatic spread of stimulant abuse to the general public. Youths age 19 and under accounted for 305 of the people questioned by police, an increase of nearly 100 over the same period in 1981.

The stimulants are entering Japan via Hong Kong, Taiwan, Hawaii, and South Korea, and several smuggling organizations may still be operating unchecked, says an article in the Royal Canadian Mounted Police Monthly Digest of Drug Intelligence Trends. The article was based partly on reports in Japanese newspapers.

NEWS

US chest doctors mobilize against cigarette smoking

By Alex Durand

TORONTO — An 11,000-strong body of doctors in the United States — the American College of Chest Physicians (ACCP) — is mobilizing for a wide-ranging, long-term campaign against smoking.

President Thomas Petty, announced the campaign at the ACCP's 48th annual scientific meeting, held here in conjunction with the XIV World Congress of Chest Physicians.

In his opening remarks at a World Symposium on Smoking Cessation, Dr Petty described the campaign as "a grass-roots effort . . . to make each physician's office and clinic a centre for the anti-smoking campaign."

Two important measures have recently been undertaken as part of the campaign, Dr Petty said.

The first is development of a set of ACCP-approved guidelines, published in the September issue of *Chest*, the College's scientific journal, for eliminating smoking in the "physician's workshop," that is, the doctor's office, clinic, or hospital.

The second is an anti-smoking "work kit" which the College is distributing to all its doctors.

The kit includes a number of aids, such as:

- a sheet of stop-smoking tips for the doctor to pass out to smoking patients — for example, when the desire for a cigarette strikes, you can get through the approximately two-minute peak period of craving by concentrating on the second-hand of your watch;
- a handout sheet of answers to questions smokers commonly ask — for example, wouldn't it be enough simply to "cut down"?;
- a handout sheet outlining the health benefits of quitting.

The kit includes a specially-designed prescription pad on which the doctor may write out a "Stop smoking!" prescription, and a sheet of "smoker's tabs" — stickers emblazoned with a smoldering cigarette and intended for the patient's file.

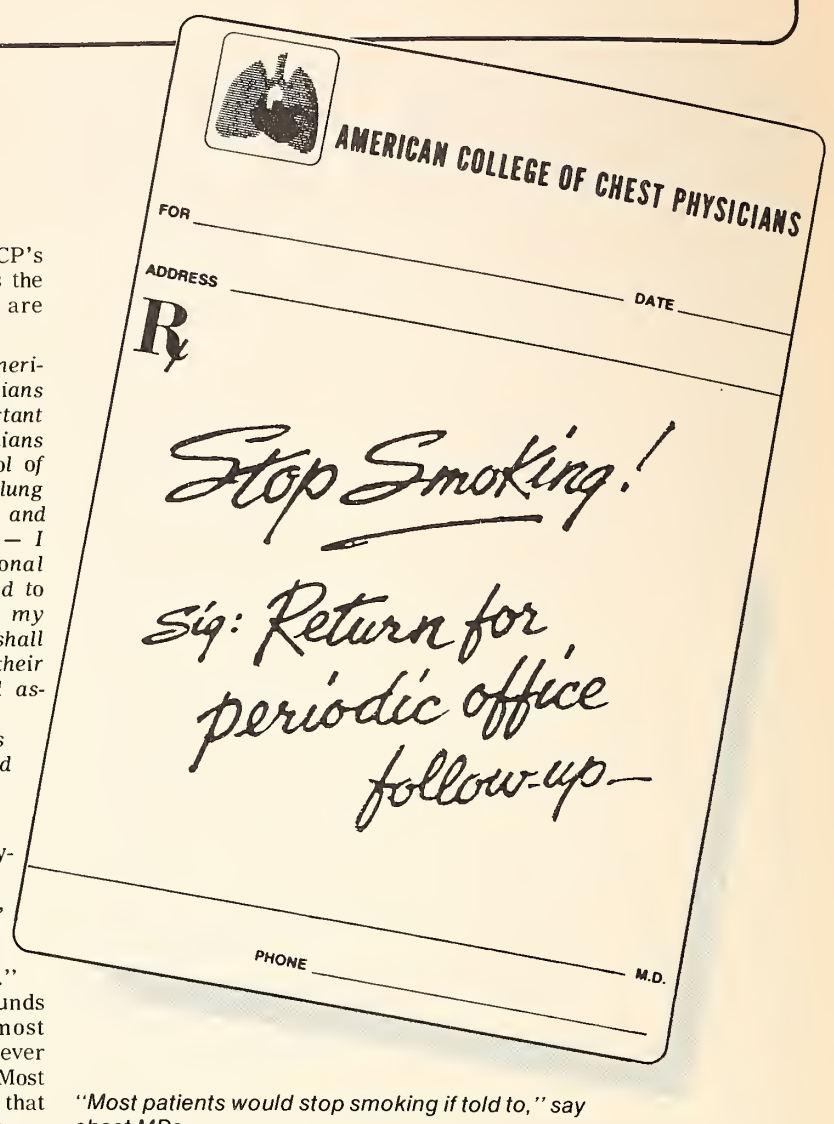
"Place one of the smoker's tabs on the file folder where the patient can see it," say instructions. "This indicates the physician considers smoking one of the most important elements in the patient's history. Express the hope that the day will come when the stickers can be taken off the file and the patient informed that he is now 'clean of the habit.' "

Another aspect of the ACCP's campaign, Dr Petty noted, is the pledge that new members are asked to take:

"As a new Fellow of the American College of Chest Physicians and a leader in the most important struggle faced by chest physicians — the prevention and control of our major health problems of lung cancer, cardiovascular, and chronic pulmonary disease — I shall make a special personal effort to control smoking and to eliminate this hazard from my office, clinic, and hospital. I shall ask all of my patients about their smoking habits, and I shall assist the cigarette smoker in stopping smoking. I make this pledge to my patients and to society."

The intent of the pledge, Dr Petty says, is "to get each physician to ask their patients, at least once, if they smoke, and, if they do, tell them seriously and professionally that smoking is a hazard to their health."

Dr Petty admitted "it sounds rather simple" but said most patients say no doctor has ever told them to stop smoking. Most patients also claim, he added, that they would stop if told to do so.



"Most patients would stop smoking if told to," say chest MDs.

Act will protect recovering drinkers

Alcoholism is defined as a handicap in PEI

CHARLOTTETOWN, PEI — Alcoholics are disabled people and entitled to protection under the Human Rights Act, says the Prince Edward Island Human Rights Commission.

This is the first time a provincial commission has taken this stand, and it could pave the way for similar rulings in other provinces, says the commission's executive director Thomas Klewin.

"It's the inactive alcoholic we're trying to protect," he told **The Journal.** "If he is an alcoholic and he's under control, and an employer didn't hire him (because of that), then the employer is guilty of discrimination."

The decision of the PEI commission came after a lengthy investigation of a complaint filed by a man who claimed he had been fired by his employer after entering an addiction treatment program.

As a result of its investigation, the commission established a precedent by defining alcoholism as a "handicap," subject to human rights codes. A second complaint is currently being considered.

Mr Klewin says alcoholism is irreversible, potentially terminal, and therefore a chronic disease. Hospitals, addiction services, psychiatrists, and various medical authorities back up this belief, he adds.

In its decision, the commission stressed the difference between the recovered or recovering alcoholic and the active drinker. Mr Klewin says the human rights code is for the alcoholic whose habit is "completely broken" or for someone who is actively seeking treatment and can be followed up.

Active drinkers, whose job performance is affected by their drinking, have no recourse under the Human Rights Act.

In fact, in 1981 the PEI legislature planned to give police sweeping powers to deal with alcohol and other drug abusers. (**The Journal**, Sept, 1981). The legislation would have allowed police to take citizens from their homes without warrants and detain them in treatment centres for up to two weeks without laying charges.

However, Mr Klewin says the legislation was never proclaimed by the lieutenant-governor, never put into practice, and is no longer an issue. Various groups, including the commission, opposed the plan because it violated the rights of individuals.

Mr Klewin sees the Human Rights Commission decision, however, as "offering protection" for those workers who won't seek treatment because of fear they will lose their job.

So far, there has been little reaction to the decision in PEI or in other provinces, he says.

The commission has not considered whether any other drug addictions will fall under this ruling, he says. They may be considered if medical authorities were to define addiction to drugs as a physical illness and there were complaints to the commission about discrimination, Mr Klewin adds.

New Jersey joins trend to higher drinking age

TRENTON, NJ — New Jersey has joined 25 other states in raising its legal drinking age to 21 years from 19. The new age went into effect Jan 1.

However, opponents of the bill say it will force more young people to drink in secret, or prompt them to drive to New York, where the legal age is 19, and increase the risk of driving deaths.

Children of alcoholics need special services

By Lynn Payer

NEW YORK — Children of alcoholics are at increased risk for a number of problems including alcoholism, but few agencies provide services targeted to this population, a report to the New York State Governor has concluded.

In some areas, there are no services at all, says the report by Migs Woodside, an assistant commissioner of the Addiction Services Agency of the City of New York.

The report was presented at the Governor's Conference on Children of Alcoholics, believed to be the first such conference ever convened in the United States.

Children of alcoholics, says Ms Woodside, are four times as likely to become alcoholics themselves. An informal survey of 13 state-operated treatment centres showed 58% of adults in treatment had had alcoholic parents.

Those children who do not become alcoholics often become rigidly controlled over-achievers in adult life, and prone to depression in mid-life, the report says.

Daughters of alcoholics, it said, are more likely to marry alcoholics, thus projecting similar problems on to new generations.

The report recommends a number of ways children of alcoholics could be better served, including increased support of Alateen, increased awareness of alcoholics, and intervention programs in the schools.

Smoking inhibits, prolongs successful ulcer treatment

By David Milne

BONN — Another detrimental effect of cigarette smoking has been noted by doctors studying the healing rate of peptic ulcers; it reduces the effectiveness of even the powerful anti-peptic ulcer agent, cimetidine.

In trials of two anti-ulcer drugs, cimetidine and oxmetidine, in Bonn and in Graz, Austria, the healing rates at the two medical centres were very different. Cimetidine appeared to perform much better than oxmetidine at the German medical centre, while the reverse was true at Graz.

Analysis revealed that significantly more oxmetidine patients continued to smoke during the trial in Germany, while more cimetidine patients smoked during the trial at Graz.

The researchers concluded that smoking, and not the kind of drug administered, was the key factor in poor ulcer healing; 90% of treatment failures were smokers.

The doctors advise smokers that it may be as important to stop smoking during ulcer treatment as to take medication.

They said smokers may need higher doses or longer courses of treatment, and treatment regimens may have to be redesigned according to patients' smoking habits.

(The report appeared in *GUT*, 1982, 23, 866.)

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Margaret Sheppard, at (416) 595-6150.

Cutting It

Number: 531.
Subject heading: Skid Row, treatment/rehabilitation.
Details: 19 min, 16 mm, color.
Synopsis: John has been an alcoholic and a drug addict. He has been trying to kick his habit. He is working at the Addiction Recovery Work Centre in Toronto, Ontario to find a way to make his life more meaningful. This film follows John through several days, as he meets old friends, sells things in the store, and tells about his past experiences and future hopes.
General Evaluation: Poor (2.1). Although this film is contemporary, the group felt the message was not clear and that it would not likely lead to decisions opposing drug use.
Recommended use: As a discussion starter in detox and halfway houses.

Face Value

Number: 532.
Subject heading: Attitudes and values, communication.
Details: 10 min, 16 mm, color.
Synopsis: A boy is dreaming about a party where people are wearing masks. Several take off their masks to reveal who and what they really are, and why they feel they must wear a mask. Reasons included: to overcome difficulty talking to girls, as the only way to impress others, to hide insecurity, and a sense that no one would care otherwise. When the boy wakes up in a sweat from seeing the masked people beckoning to him in a cemetery, he hears his mother telling him to hurry. He puts on his mask and prepares to face the day.
General Evaluation: Fair (3.1). This was a contemporary and well-produced film. However, the group felt the message was not clear and that it was not really drug-related.
Recommended use: With the presence of a resource person could benefit teenagers.

Born Hooked

Number: 534.
Subject heading: Women and drugs, treatment/rehabilitation.
Details: 13 min, 16 mm, ¾" video, color.
Synopsis: Women who have used heroin during their pregnancy are likely to have children who are "Born Hooked". These babies suffer from withdrawal symptoms, such as shaking, crying, and stiffening of the limbs. Such babies must be recognized and treated to prevent severe damage or death.
General evaluation: Fair to good (3.8). While this film was judged to be a good teaching aid with a clear message, because it is made of excerpts from "Born with a Habit" (Projection No. 409), it was considered too general, and glossed over things too much. General broadcast was recommended.
Recommended use: This film would especially benefit pregnant women and health professionals but could be used for any adult audience.

Alcohol Crisis

Number: 535.
Subject heading: Women and alcohol, fetal alcohol syndrome.
Details: 16 min, 16 mm/video, color.
Synopsis: Children born of mothers who drink alcohol during pregnancy display some distinctive symptoms which may include: facial malformations, heart problems, smaller size, and mental retardation. These children may also exhibit behavioral and coordination problems. Research done on mice shows that even moderate amounts of alcohol used by the pregnant mother can result in these symptoms.
General evaluation: Fair to good (3.9) This informative film was judged to have a clear message. It is a good teaching aid that could help in decision-making about alcohol use. Public broadcast was recommended.
Recommended use: Of benefit to all audiences over 12 years of age, especially pregnant women and health professionals.

Do You Mind if I Smoke

Number: 536.
Subject heading: Smoking.
Details: 20 min, 16 mm, color.
Synopsis: This film discusses the issue of second-hand smoke. A bartender is suffering from emphysema even though he never smoked; a young child is experiencing respiratory problems because his mother smoked while pregnant and continues to smoke around him; a man suffering from asthma must stay away from his wife when she smokes. Research shows that some chemicals in sidestream smoke are more potent than those in the smoke that a smoker inhales. Action is urged on the part of business and government to reduce the places where smoking is permitted, to cut down on the damage to non-smokers.
General evaluation: Fair to good (3.8). Although an important topic, it was believed that the lung operation and research tests were offensive, and the style of presentation not particularly relevant for North American audiences.
Recommended use: Could be of benefit for those attempting to get legislation passed limiting smoking in public places.

DEPARTMENT

New Books

by RON HALL

Recent Advances in the Biology of Alcoholism

. . . edited by Charles S. Lieber and Barry Stimmel

Of particular relevance to the question of the biologic basis of alcoholism and its complications is the knowledge of the heterogeneity of alcohol oxidizing systems in the body. Developments in this field are summarized and information on the heterogeneity of aldehyde dehydrogenase is updated. Two theories to explain the facial flush are postulated and these illustrate how advances in understanding of the enzymes involved in alcohol and aldehyde metabolism may help establish the biological basis for individual and ethnic differences in response to ethanol. The basic concepts needed for the understanding of alcohol-drug interactions are presented, and a paper describes in greater detail the clinical relevance of this alcohol and drug interaction. A chapter devoted to alcoholic liver disease contains a discussion indicating that in addition to nutritional factors, alcohol itself exerts toxicity in the liver through a variety of mechanisms. Acetaldehyde is an active compound and it adversely affects the liver in many ways, including interference with mitochondrial functions and the capacity of the liver to secrete proteins. The final paper updates the research on the pathogenesis of alcohol-induced endocrine abnormalities. The present understanding of various interactions may eventually provide more effective handling not only of alcohol induced endocrine disturbance, but also of the broader problem of excessive alcohol consumption.

(The Haworth Press, 28 East 22 Street, New York, NY 10010, 1982. 132 p. $25.00 ISBN 0-86656-104-8)

Alcoholism: A Modern Perspective

. . . edited by P. Golding

The opening section deals with fundamental problems of alcoholism and chapters are devoted to alcoholism and drug abuse identification and treatment in Minnesota, alcohol research in the 1980s, alcohol problems in social networks, and the alcohol-troubled person model. The concept of alcohology, the disease concept of alcoholism, and the concept of symbiosis, and the 12 steps of Alcoholics Anonymous form the second section. The book also contains sections on prevention, diagnosis of alcoholism, treatment, education, alcoholism and the family, alcoholism and sex, alcoholism and women, recovery, alcohol and the law, alcoholic personality and genetics, and alcohol and industry. A section dealing with alcohol and special groups covers alcohol-related problems in the elderly, cultural prescriptions favoring excessive alcohol intake and treatment of drinking problems, psychotic conditions occurring in patients while in a treatment home, outpatient behavior therapy for juveniles and young adults, and a high-density case management approach to treating chronic recidivist alcoholics.

(George A. Bogden and Son, 45 Hudson Street, Ridgewood, NJ 07450, 1982. 539 p. ISBN 0-85200-409-5)

Other Books

The Impact of Social and Economic Forces on Alcohol And Drug Problems in Ontario — Adrian, Manuella. Addiction Research Foundation, Toronto, 1982. Selection of alcohol and drug indicator statistical series for purposes of producing effective public education tools; nature and extent of the relationship of alcohol and drug indicators to underlying economic and social conditions in Ontario. Tables, figures. 53p. $5.95.

Development of Animal Models As Pharmacogenetic Tools — McClearn, Gerald E.; Deitrich, Richard A.; and Erwin, V. Gene (eds). US Government Printing Office, Washington, 1981. NIAAA Research Monograph No 6; proceedings of a workshop held in Boulder Colorado, December 4-6, 1978; current perspectives on selective breeding; selective breeding for alcohol-related phenotypes; pharmacogenetic phenotypes. Glossary, index. 302p.

Working Men and Ganja: Marijuana Use In Rural Jamaica — Dreher, Melanie Creagan. Institute for the Study of Human Issues, Philadelphia, 1982. Communities; ganja in an institutional framework; socioeconomic perspective; ganja and the organization of work; ganja and work performance. References, index. 216p.

Adolescent Marijuana Abusers and Their Families — Hendin, Herbert; Pollinger, Ann; Ulman, Richard; and Carr, Arthur C. US Government Printing Office, Washington, 1981. NIDA Research Monograph 40; lives of adolescent marijuana abusers; psychological test results; representative cases; family psycho-dynamics; psychological contrast of marijuana abusers and their siblings. 114p.

The Impact of Supported Work on Ex-Addicts — Dickinson, Katherine, and Maynard, Rebecca. Manpower Demonstration Research Corporation, New York, 1981. Supported work demonstration and the ex-addict target group; research hypothesis and methodologies; program effect on employment, earnings and income; effects on drug use; program effects on crime and criminal justice experiences. Appendices, tables, figures, references. 240p. $11.14.

Human Services in Industry — Masi, Dale A. DC Heath, Lexington, 1982. History of occupational social work in the US; personnel departments and employee benefits; unions; services; special populations to be served; education for the industrial social worker; includes chapters dealing with EAP. Tables, appendices, index. 246p. $39.76.

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Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Detox Training Programs (Non-Medical) — Feb 7-11, Apr 11-15, June 6-10, Toronto, Ontario. Information: Gord Gooding, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

36th Annual Convention of the Ontario Psychological Association — Toronto, Ontario, Feb 17-19. Information: Dr Carl Rubino, Convenor, OPA '83, 1407 Yonge St, Ste 402, Toronto, ON M4T 1Y7.

The Management of Employee Assistance Programs — Feb 23-25, Toronto, Ontario. Information: Carole George, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Recent Developments in Psychopharmacological Management — Mar 2, Montreal, Quebec. Information: Centre for CME, McGill University, 1110 Pine Ave, Montreal, PQ H3A 1A3.

Health Research Ontario '83 — Mar 4-Apr 4, Toronto, Ontario. Information: Sandra Tesolin, Public Relations Dept, Ontario Science Centre, 770 Don Mills Rd, Don Mills, ON M3C 1T3.

Update: Current Issues In Psychiatric Nursing — Mar 14, Apr 18, May 6, June 6, Toronto, Ontario. Information: Evon Essue, Conference Secretary, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Drug Therapy — Mar 25-26, Regina, Saskatchewan. Information: CME Centre, University of Saskatchewan, 408 Ellis Hall, Saskatoon, SK S7W 0W0.

25th Annual Scientific Assembly of the College of Family Physicians of Canada — Apr 24-27, Toronto, Ontario. Information: George Ackehurst, Director of Communications, The College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

Clinical Criminology: Current Concepts Symposium — Apr 27-29, Toronto, Ontario. Information: Ms Evon Essue, Conference Secretary, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Drug Therapy — April 28-29, Montreal, Quebec. Information: CME, McGill University, 1110 Pine Ave W, Montreal, PQ H3A 1A3.

Canadian Addictions Foundation Annual Meeting — May 2-4, Medicine Hat, Alberta. Information: Jim Edwards, Executive Director, Canadian Addictions Foundation, Pacific Plaza, Box 702, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

7th Annual Course on Emergency Management — May 5-7, Toronto, Ontario. Information: Dr Calvin Gutkin, 751 Dundas St W, Toronto, ON M6J 1T9.

International Conference, Beyond Violence — May 9-11, Montreal, Quebec. Information: GEMS, CP 1016, Snowdon, PQ H3X 3Y1.

Theory and Practice of Group Psychotherapy and Counselling I — May 14-29, Toronto, Ontario. Information: Evelyn Piltch, 4 Finch Ave W, Ste 10, Willowdale, ON M2N 2G5.

International Conference on Prison Abolition — May 26-28, Toronto, Ontario. Information: International Conference on Prison Abolition, c/o QCJJ, 60 Lowther Ave, Toronto, ON M5R 1C7.

Medic Canada '83 . . . Toward the Year 2000 — May 29-31, Edmonton, Alberta. Information: Toby Fay Sykes, Medic Canada '83, 480 Garyray Dr, Toronto, ON M9L 1P8.

Canadian Guidance and Counselling Association 9th Biennial Conference — May 31-June 3, Fredericton, New Brunswick. Information: Richard Harvey, Conference Chairman, CGCA '83, Fredericton, NB E3B 5G4.

Fifth World Conference on Smoking and Health — July 10-15, Winnipeg, Manitoba. Information: Kurt Baumgartner, Box 8159, Terminal PO, Ottawa, ON K1A 0C1.

24th Annual Institute on Addiction Studies — July 17-22, Hamilton, Ontario. Information: Alcohol and Drug Concerns Incorporated, 15 Gervais Dr, Ste 603, Don Mills, ON M3C 1Y8.

Input '83, The 5th Biennial Canadian Conference — Aug 9-12, Toronto, Ontario. Information: Kathryn Barber, Co-chairperson, Input '83, Professional and Management Development, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

2nd World Congress on Prison Health Care — Aug 28-31, Ottawa, Ontario. Information: Congress Secretariat, Medical Services Branch, The Correctional Service of Canada, Ottawa, ON K1A 0P9..

Royal College of Physicians and Surgeons Annual Meeting — Sept 19-22, Calgary, Alberta. Information: Robert A Davis, Associate Director, Office of Fellowship Affairs, Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, ON K1M 1P4.

United States

"Guiding Youth Into A Drug-Free Lifestyle" — Feb 7-9, Orlando, Florida. Information: Milo C. Sawvel Jr, Exec Director, National Committee for the Prevention of Alcoholism and Drug Dependency, 6830 Laurel St, NW, Washington, DC 20012.

Family Dynamics of Alcohol/Drug Dependence — Feb 14-16, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Group Facilitator Skills — Feb 21-25, Milwaukee, Wisconsin. Information: De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

National Conference on Financing Alcoholism and Drug Abuse Treatment Services — Feb 27-Mar 1, Chicago, Illinois. Information: Eric Scharf, ADPA, 1101-15th St NW, Ste 204, Washington, DC 20005.

National Conference on Alcohol and Drug Abuse Programming in Colleges and Universities — Mar 1-3, Chicago, Illinois. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

Bereavement: The Impact of Loss on Surviving Family Members — Mar 18, New Hyde Park, New York. Information: Ann Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

Counselling Theories and Techniques — Mar 21-23, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Partnerships in Prevention: The 1983 Carolinas' Primary Prevention Conference — Mar 27-30, Raleigh, North Carolina. Information: Jill Spencer, Charlotte Drug Education Center, 1416 E Morehead St, Charlotte, NC 28204.

Health and Addictions Seminar — Mar 27-Apr 1, Park City, Utah. Information: Dan Barmettler, Institute for Integral Development, PO Box 2172-B, Colorado Springs, Colorado 80901.

American Orthopsychiatric Association 60th Annual Meeting — Apr 4-8, Boston, Massachusetts. Information: The American Orthopsychiatric Association, Inc, 1775 Broadway, New York, New York 10019.

3rd Annual Conference on Poly-Drug Abuse in the Workplace — Apr 12-13, Akron, Ohio. Information: Keith McClellan, Executive Director, Tri-County EAP, 450 Grant St, Ste 304, Akron, OH 44311.

National Alcoholism Forum, "Marketing the Message" — Apr 14-17, Houston, Texas. Information: Louisa Macpherson, Forum Coordinator, National Council on Alcoholism, 733 Third Ave, Ste 1405, New York, New York 10017.

American Medical Society on Alcoholism — Apr 14-20, Houston, Texas. Information: J. Chen See, AMSA, 733-3rd Ave, New York, New York, 10017.

ADPA 1983 Eastern Regional Conference — Apr 17-20, Hartford, Connecticut. Information: Eric Scharf, ADPA, 1101-15th St NW, Ste 204, Washington, DC 20005.

Conference on Alcoholism, Treatment, and Culture: Comparative Perspectives from Europe and America — May 5-7, Farmington, Connecticut. Information: Ms Margie Meadows, Department of Psychiatry, University of Connecticut Health Center, Farmington, CT 06032.

7th World Conference of Therapeutic Communities — May 8-13, Chicago, Illinois. Information: Donna Gleixner, Gateway Houses Foundation, Inc, 624 S Michigan Ave, Chicago, IL, 60605.

National Association of Alcoholism Treatment Programs (NAATP) — May 13-16, Kansas City, Kansas. Information: Mrs Kim Farthing, NAATP, 1300 Bristol St, North Newport Beach, California 92660.

Scholarly Communication Around The World — The 27th Annual Conference of the Council of Biology Editors, The 3rd International Conference of Scientific Editors and The 5th Annual Meeting of the Society for Scholarly Publishing — May 15-20, Philadelphia, Pennsylvania. Information: 1983 International Conference, Attn: Elizabeth M. Zipf, BioSciences Information Service, 2100 Arch Street, Philadelphia, PA 19103.

3rd Annual Conference for Nurse Educators on Current Issues in Alcohol and Drug Abuse Nursing: Research, Education, and Clinical Practice — May 18-20, Washington, DC. Information: Geral Dene M. Burdman, PhD, Alcohol and Drug Abuse Nursing, SC-78, School of Nursing, University of Washington, Seattle, Washington 98195.

2nd Annual Conference on Alcoholism and the Family — May 25-29, Philadelphia, Pennsylvania. Information: Richard W. Esterly, Chairman, National Conference on Alcoholism and the Family, Box 277, Wernersville, PA 19565.

The Mid-South Summer School on Alcohol and Drug Problems — Prevention and Treatment — June 5-10, Fayetteville, Arkansas. Information: Gwen Briscoe, GSSW-UALR, Little Rock, AR, 72204.

Summer School of Alcohol Studies — June 19-July 8, New Brunswick, New Jersey. Information: Gail Gleason Milgram, Education and Training Division, Center of Alcohol Studies, Smithers Hall, Rutgers University, New Brunswick, NJ 08903.

34th Annual Symposium on Alcoholism — Alcoholism and the Family — June 20-July 1, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, Seattle, WA 98122.

World Congress on Mental Health — July 22-28, Washington, DC. Information: World Federation for Mental Health, #107-2352 Health Sciences Mall, University of British Columbia, Vancouver, British Columbia V6T 1W5.

New Jersey Summer School of Alcohol and Drug Abuse Studies — July 31-Aug 5, New Brunswick, New Jersey. Information: Gail Gleason Milgram, Education and Training Division, Center of Alcohol Studies, Smithers Hall, Rutgers University, New Brunswick, NJ 08903.

7th Annual Summer Institute of Drug Dependence — Aug 14-19, Colorado Springs, Colorado. Information: Dan Barmettler, Director, The Institute for Integral Development, PO Box 2172, Colorado Springs, CO 80901.

Alcohol and Drug Problems Association of North America 34th Annual Meeting — Aug 28-Sept 1, Washington, DC. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

American Association for the Study of Liver Diseases — Nov 4-7, Chicago, Illinois. Information: C. B. Slack, 6900 Gorve Rd, Thorofare, New Jersey 08086.

ADPA 1983 Western Regional Conference — Nov 13-16, Los Angeles, California. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

Abroad

United Nations Commission on Narcotic Drugs — Feb 4-16, Vienna, Austria. Information: Vienna International Centre, PO Box 500, A-1400, Vienna, Austria.

World Conference on Alcoholism — Feb 26-Mar 6, London, England. Information: Pat Fields, Charter Medical Corp, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, Georgia, 30342.

Pharmacological Treatments for Alcoholism: Looking to the Future — Mar 28-31, London, England. Information: Ms Nina Little, Alcohol Education Centre, The Maudsley Hospital, 99 Denmark Hill, London SE5 8AZ England.

World Symposium on Acupuncture — May 26-29, Bombay, India. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

29th International Institute on the Prevention and Treatment of Alcoholism — June 27-July 2, Zagreb, Yugoslavia. Information: Archer Tongue, ICAA, Case postale 140, 1001 Lausanne, Switzerland.

9th International Conference of the International Association for Accident and Traffic Medicine — July 10-15, Mexico. Information: Dr R. Andreasson, IAATM, PO Box 10043, 5-100 55 Stockholm 10, Sweden.

8th Institute on Drugs, Crime, and Justice in England and America — July 11-15, London, England. Information: Institute on Drugs, Crime and Justice, School of Justice, The American University, Washington, DC 20016.

7th World Congress of Psychiatry — July 11-16, Vienna, Austria. Information: Congress Team International, PO Box 9, A-1095 Vienna.

Australian Medical Society on Alcohol and Drug Related Problems 3rd Annual Conference — July 31-Aug 7, Cairns, North Queensland, Australia. Information: Conference Organizers, PO Box 155, Civic Square, ACT, 2608, Australia.

Middle Eastern Summer Institute on Drug Use (MESIDU): Techniques, Strategies, Concepts and Options — Sept, Jerusalem, Israel. Information: Stan Einstein, PhD, Director, MESIDU, 113/41 East Talpiot, Jerusalem, Israel.

International Conference on Alcoholism — Sept 26-30, Reykjavik, Iceland. Information: International Council on Alcohol and Addictions, Case postale 140, 1001 Lausanne, Switzerland.

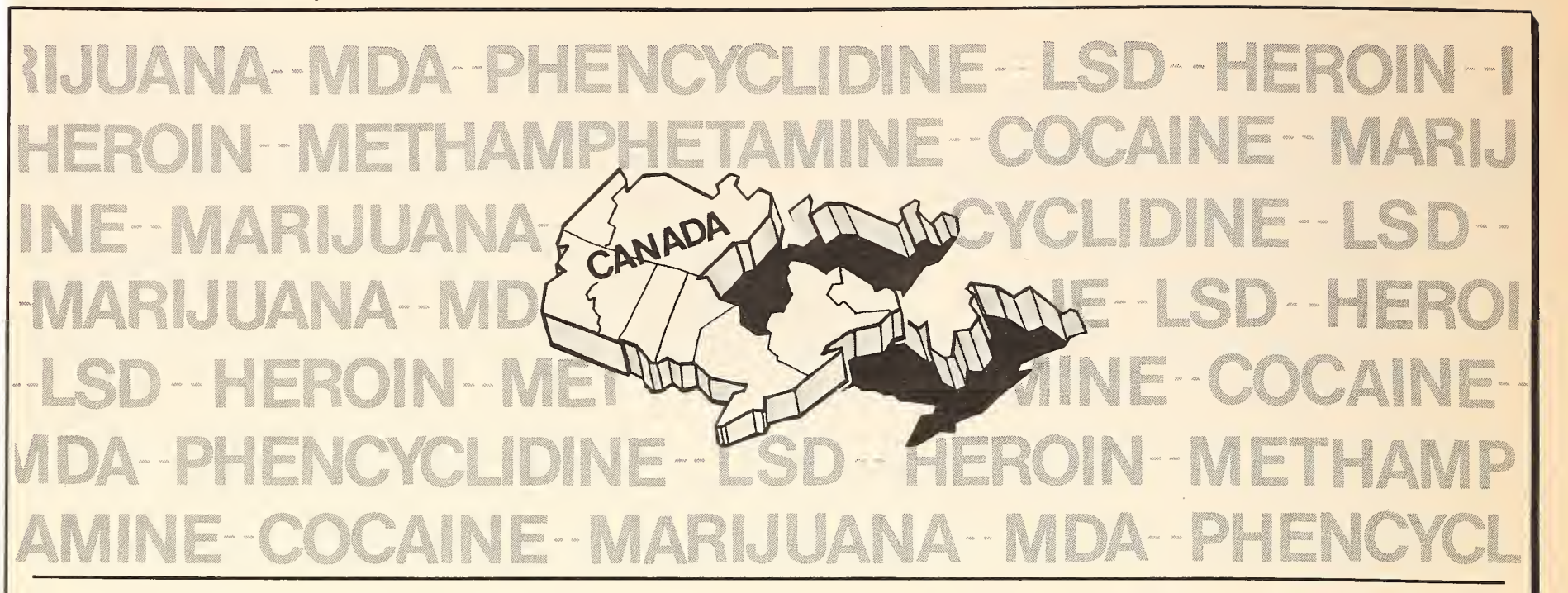
8th World Congress of Acupuncture — Oct 12-16, Seoul, Korea. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

13th International Institute on the Prevention and Treatment of Drug Dependence — Oct 10-14, Oslo, Norway. Information: International Council on Alcohol and Addictions, Case postale 140, 1001 Lausanne, Switzerland.

9th International Conference on Alcohol, Drugs, and Traffic Safety — Nov 13-18, San Juan, Puerto Rico. Information: T-83 Secretariat, GPO Box 5067, Medical Sciences Campus, San Juan, Puerto Rico 00936.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

2nd International Congress on Drugs and Alcohol — Dec 18-22, Tel Aviv, Israel. Information: Congress Secretariat: Peltours Ltd, Congress department, PO Box 394, Tel Aviv, 61003 Israel.



Forecast '84 — drugs international

What are the expected drug trends in Canada in the next two years? The Royal Canadian Mounted Police (RCMP) National Drug Intelligence Estimate* is the first report of its kind in this country. A collection and analysis of foreign and domestic narcotics intelligence, it fits Canada into today's world map of drug supply and demand, and draws some educated guesses about how that map might shift and change over the next year or two.

"An accurate assessment of the magnitude and dimensions of the illicit drug problem in Canada is a fundamental starting point for rational policymaking as well as public debate," the report states.

"In absence of reliable and comprehensive intelligence estimates, substantial misconceptions can develop, resources can be misallocated . . . and trend forecasts are much more likely to be based on conjecture."

Superintendent Rod Stamler of the drug enforcement branch of the RCMP says the trend indicators in the report are an attempt to predict what will happen in the drug field here until 1984. The RCMP will monitor the trends during the next two years to determine the accuracy of the predictions.

Following is a summary of those expected trends:

Heroin availability in Canada will, in all likelihood, increase through the mid-1980s. The bumper opium harvests in 1980/81 and 1981/82 in Southeast Asia (SEA), the principal supplier of heroin to the Canadian market, may draw new users into heroin abuse. SEA heroin, now predominant and becoming increasingly available on Canada's West Coast, may intensify the heroin distribution and abuse problem in that area, where approximately 60% of Canada's user population is located. Abuse trends in Vancouver, the principal centre for heroin activity in Canada, will likely worsen with the rising availability of SEA heroin. The Golden Triangle region of Southeast Asia is expected to hold the greatest market share of the heroin available on the Canadian market through 1984.

- Political turmoil and a breakdown of regional and international law enforcement mechanisms largely contributed to the initial development of Southwest Asia's (SWA) rise as a major heroin supplier to the Canadian market. These problems will likely continue to create opportunities for the manufacture and smuggling of large quantities of SWA heroin to the Middle East, Europe, and North America over the next several years. Although opium production dropped substantially in 1980/81, in an exceptional year this region can produce two to three times as much opium as Southeast Asia. Southwest Asia as a region, is expected to supply up to 40% of the illicit Canadian heroin market during the 1980s.
- The extensive opium poppy eradication campaign mounted by the Mexican government should prevent Mexico from becoming a significant source of supply for heroin destined to Canada in the near future. However, should the demand for narcotic supplies rise to any great extent, or in a situation of a shortage or elimination of the Southeast Asian or Southwest Asian supplies, there will be increased pressure by criminal syndicates to expand the illicit production of heroin in Mexico. Therefore, Mexico should be viewed as a key country for expanded opiate production in the event of any radical change in global heroin production.
- India should be looked upon as a potential source of heroin and morphine to Canada in the coming years. The huge stockpile of unsold, legally-produced opium in India causes some concern in view of possible diversion into the illicit narcotics market. As well, clandestine laboratories manufacturing morphine sulphate and heroin were seized in India during 1981. This clearly indicates the increasing involvement of India as a source area for illicit narcotic supplies.
- The significant rise in the diversion of licit narcotics into the illicit market over the past several years should begin to decline with the forecasted increase in the availability of heroin in 1982/83. However, what may be developing is a secondary user population in Canada made up of individuals solely dependent upon narcotic supplies diverted from the licit market. If this premise should prove to be true, legally diverted narcotics will become an increasing abuse and enforcement problem in future.

Cocaine availability and abuse are forecasted to rise in all regions of Canada through 1984, with the most noticeable increases expected in Vancouver, Toronto, Montreal, and other densely populated areas of the country. It is also anticipated that abuse of cocaine will begin to emerge in the smaller communities in Canada and that abuse will encompass most socio-economic groups rather than being confined to the upper income groups.

- United States president Ronald Reagan's Administration's South Florida Task Force, put in place in early 1982, (**The Journal** Oct 1982) may significantly reduce the use of the South Florida corridor as a principal transshipment point for cocaine destined to Canada. This initiative will force drug traffickers to seek out alternate routes from South America.
- Canadian drug traffickers are expected to travel directly to Peru and Bolivia to obtain cocaine in an effort to increase their profits. Both countries should have greater illicit stocks of cocaine available as a result of Colombia's increased domestic cultivation of the coca bush over the past several years. Bolivia, in particular, will increase its market share in Canada through 1984.
- Brazil will emerge as a source country for cocaine hydrochloride manufactured from coca leaves produced in Peru and Bolivia. The major transshipment points for cocaine bound from Brazil to Canada will be Rio de Janeiro and Sao Paulo. These routes will be used, to a large extent, by Canadian drug traffickers who prefer to enter Canada through Mirabel International Airport, Montreal.
- Cocaine "freebasing" is expected to be encountered more frequently through 1984, particularly on Canada's West Coast. There may also be a resultant increase in overdoses from the administration of freebased cocaine.
- Prices for cocaine, both at the wholesale and retail levels, will remain relatively stable. However, because of greater availability, purity at the street level is expected to rise slightly.

Although demand for chemical narcotic substitutes should decline somewhat with the rising availability of heroin, abuse of drugs in schedules F and G of the Food and Drugs Act is expected to increase in those areas experiencing shortages of heroin. (Schedule F covers prescription drugs; Schedule G, controlled drugs such as amphetamines and pentazocine). Armed robberies and break-and-entries to obtain licitly manufactured drugs are expected to increase in the areas experiencing a high incidence of drug diversion. The problem will be most acute in the provinces of Ontario, British Columbia, Quebec, and Alberta.

- Diversion of licit drug supplies from legitimate foreign manufacturers is likely to increase in the near future. Canada could increase in importance as a transit point for large shipments of methaqualone and diazepam diverted from licit manufacturers in Europe and destined for the United States.
- Indicators also point to Canada being used more frequently in future as a transit point for non-controlled precursor chemicals en route to the US market. The increasing legal control measures and more vigilant law enforcement action aimed at controlling diverted drugs into the US should only serve to exacerbate this growing problem area.
- Clandestine laboratories in Canada will continue to operate almost exclusively to meet domestic demand requirements, and only nominal amounts of illicitly produced chemical drugs will reach foreign markets. However, clandestine laboratories in the US supply the major share of the LSD (lysergic acid diethylamide) available on the Canadian market and this situation is expected to continue through 1984. Although indicators reflect that a decrease in LSD availability occurred in 1981, an accompanying decline in street dosage levels, allaying the users' fears of negative side effects, could result in increased abuse levels in future. LSD abuse is, however, not expected to return to the levels recorded during the mid-1960s.
- Methamphetamine, MDA (methylenedioxyamphetamine), PCP (phencyclidine), and LSD will continue to be the principal chemical drugs manufactured in clandestine laboratories in Canada. Ontario, Quebec, and British Columbia will remain the most active areas for the illicit production of chemical drugs. The involvement of outlaw motorcycle gangs in the production and distribution of chemical drugs is expected to escalate through 1984. These organized criminal groups are also expected to branch out further into other drug activities.
- Look-alike drugs are expected to become an increasing problem area in Canada through 1984. The absence of legal controls dealing with these substances may lead to increasing abuse levels of look-alike drugs in future. The United States will remain the principal source of look-alike drugs for the Canadian market.

Cannabis derivatives will continue to be the most readily available and widely used illicit drugs of abuse in Canada.

- Mothership loads of marijuana originating in Colombia will enter Canada on both the East and West Coasts. A large portion of this marijuana will be destined ultimately for the United States, but as a result of the South Florida Task Force it will be rerouted through Canada.
- The higher potency varieties of marijuana, as well as hashish and liquid hashish, will be increasingly in demand in Canada. However, because of the current economic situation, greater quantities of lower-priced, low-potency, domestically-grown marijuana may be cultivated. Increased demand is also expected to produce an increase in the number of domestic clandestine laboratories manufacturing liquid hashish.
- Large cargo shipments of hashish from Lebanon are expected to reach Canada. These shipments, in the multi-ton range, will primarily be destined for the Montreal area from where further ditribution will be undertaken. Indicators suggest Lebanon will continue to supply the largest portion of Canada's hashish.
- Lebanon will also continue to supply the major market share of liquid hashish to the Canadian illicit market, entering primarily through the Montreal area. There will also be a substantial quantity of liquid hashish from Jamaica entering Canada through Toronto International Airport because of the large number of direct flights between Jamaica and Toronto.

The Commissioner, RCMP
Attn: Officer in Charge, Headquarters
Drug Enforcement Branch
1200 Alta Vista Dr., Ottawa, Can. K1A 0R2

THE BACK PAGE

Oppenheimer: an 'evil miasma'

World drug trade at all-time high

By Anne MacLennan

VIENNA — Increased seizures of illicit drugs around the world have implications that are of "grave concern," says the director of the United Nations Division of Narcotic Drugs.

"We all know the proportion of drugs seized from the traffic is no more than a very small percentage of the total quantity being smuggled," said Tamar Oppenheimer in her debut before the UN Commission on Narcotic Drugs, the policymaking body of the division.

She said illegal traffic in heroin, cocaine, and cannabis derivatives has "increased alarmingly."

"The position in respect of psychotropic substances gives rise, if possible, to even more cause for concern.

"It is likely that reporting on these man-made psychotropic substances is less complete than that on narcotic drugs — partly owing to the difficulty of recognizing some of those drugs moving in the illicit traffic, and partly because the international reporting systems under the 1971 Convention on Psychotropic Substances are still less stringent than those laid down in the 1961 Convention on Narcotic Drugs."

She said the total quantity of methaqualone seized from traffic alone is "more than the total world medical requirements for that drug in any year.

"Attention should also be drawn to the striking increase in seizures of LSD during 1981; the number of dosage units of LSD seized in that year was an astonishing 12,000% more than the total number seized in 1980.

"With the widespread availability of illicit drugs, it is not surprising that assessments of the extent of demand for them indicate an equally disturbing expansion in many parts of the world, with multiple drug abuse becoming an increasingly common and damaging phenomenon."

Mrs Oppenheimer referred to the demand for illicit drugs as "an evil miasma of smuggling and crime, tax evasion, bribery, and corruption.

"And the final consumers of this miserable merchandise are the disaffected and the lonely, the disadvantaged, and those immature young people whose search for pleasure all too often turns into addiction and to crime to support a habit transformed into compelling need and into affliction for themselves and their families.

"In these years of economic difficulty, many who become discouraged by increasing unemployment, debts, and lack of opportunities, are turning, among other avenues for personal escape, to the false escapism of drug abuse and addiction.

"At the same time, fewer resources are available for combatting traffickers and curing the addicted. And this is true at all the various levels of governmental and intergovernmental activity."

Mrs Oppenheimer, born in England and now a naturalized Canadian citizen, is also deputy to the director-general of the UN Office at Vienna. She succeeded another Canadian, Dr George Ling, as director of the narcotics division (**The Journal**, May, 1982).

Her most recent posting was in the division of personnel administration, office of personnel services.

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The Journal

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Misguided fears of narcotic abuse foil good pain care: AMA president

By Harvey McConnell

WASHINGTON — By confusing physical dependence with drug abuse, both the medical profession and general public in North America create significant problems about using narcotics, including heroin, for terminal cancer patients.

Cancer patients take narcotics for pain, and not to produce altered behavior patterns, speakers said at a conference here on the care of patients with severe chronic pain in terminal illness. The meeting was sponsored by the American Medical Association (AMA) and the United States Public Health Service.

William Rial, AMA president, said that despite a vast array of pain medication, "the underutilization of drugs for the treatment of pain, especially severe pain, is a much too frequent occurrence."

Each day, thousands of patients suffer unnecessarily, said Dr Rial. This happens because a drug may be administered with inadequate doses, or with excessively long intervals between doses, "because there is a reluctance by the patient to convey the severity of pain, or to take 'narcotics,' and because of a misguided concern by hospital staff and relatives about the development of drug dependence by the terminally ill patient."

gesic study section, Memorial Sloan Kettering Cancer Center, and professor of pharmacology and medicine, Cornell University Medical College, New York, said: "The narcotic analgesics are without doubt the most efficacious of the drugs employed for the relief of intractable pain and suffering.

"Narcotics have long been recognized as being singularly capable of modifying both the perception of, and the reaction to, pain, as well as introducing a feeling of calm indifference to the other physiological and psychological stresses not uncommonly experienced by the dying patient with cancer."

The irony is that the capacity of the narcotics to induce a sense of well-being or euphoria is the same property "we have been making a great effort at times to eliminate — the so-called ideal analgesic."

Dr Houde said this unfortunate paradox "has been the result of an association of euphoria with drug abuse, and with the popular misconception that drugs with this capability will enslave, demoralize, and lead the unwitting patient down the primrose path to addiction."

Dr Houde noted that heroin continues to be used in Britain because doctors believe it has several advantages. One is solubility: 500 mg of heroin can be dissolved in one cc of water, and heroin is about twice as potent as morphine.

Even if a patient develops tolerance — although Dr Houde said the British claim that tolerance does not occur — "if you give them a large dose, you don't have to give them a large volume. This is an advantage in a dying patient who has had a loss of muscle mass to the disease (cancer)."

Dr Houde has visited the hospice movement in Britain and said, "I think what has been overlooked is not what medicine they give but how they give it. They titrate the doses. If the patient needs more, they up the dose, carefully monitor this, and do things which are not commonly done in this country. And I think it is not so much which drugs they use but how they use them that has made the real difference."

Clinical trails on morphine and heroin at Memorial Sloan Kettering, he said, showed that heroin "acts a little more promptly and disappears a little more promptly."

Dr Houde said he agreed completely with a questioner from the floor who noted that morphine has a "dirty name" in the US and that there is an enormous lobby in that country which pushes the case for proprietary analgesics. He

(See — Patients — page 2)

Canada studies pain control issue page 2

Canada joins queue of nations wanting world drug policy vote

By Anne MacLennan

VIENNA — Backroom lobbying to get Canada back on the United Nations Commission on Narcotic Drugs, after a four-year hiatus, is under way at home and abroad among health and external affairs officials.

The election, by secret ballot, will take place at the spring meeting in New York of the UN Economic and Social Council (ECOSOC).

Meanwhile, the decision on whether to push hard and formally for a seat rests with top officials of Canada's department of external affairs.

If they are convinced, and if a seat on the narcotics group doesn't have to be traded off for a place on one of the several other UN commissions, then bids for support will go to capitals around the world of the 54-member countries of ECOSOC.

The 30-member narcotics commission is the chief, world policy-making body in the drug enforcement field, and often referred to as "the only game in town" at the international level.

Although member countries alone can vote, meetings of the commission include representatives of member and non-member countries from every hue of the political spectrum, from UN and affiliated agencies, non-governmental agencies, and a wide range of other international groups.

Canada, a member since the commission's inception in 1946, lost its seat in 1979.

Ironically, it was the end of the decade in which Canada had had perhaps its greatest influence on the commission, and the end of the year in which a Canadian, Donald Smith, was chairman (**The Journal**, Feb, 1979).

Through the 1970s, and with Sweden, Canada played a leading role in pulling the commission back from almost exclusive focus on supply reduction through strict enforcement, to considering too what Canada believed was the equally critical question of reducing demand for drugs.

Smith: fight for dual focus

As a commission member, says Dr Smith, Canada would almost certainly continue its fight to keep the commission and the world community mindful of the need for this dual focus. Dr Smith, senior scientist, International Health Services, department of health and welfare, and a team of Canadians have sat as observers at commission meetings since 1980.

Election of Canada to the commission for 1984/5 is by no means certain, even given a push from the top.

Its surprise failure to gain a seat for 1980 (**The Journal**, Nov, 1979) was attributed partly to bungling by junior diplomats at the UN. However, it also came after the commission decided to abandon its usual election procedures and, instead, vote members in on the basis of geography.

Thus, Canada became part of the WEOG (Western Europe and Others Group) with all the countries of Western Europe, as well as the United States, and Australia and New Zealand. Among them, they have 10 seats on the commission.

Elections take place every two years. In the upcoming election, for two-year terms starting in 1984, six of the 10 WEOG seats are available.

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INSIDE

NEWS

Briefly. . .

Combats Ts and blues

WASHINGTON — A new, oral form of the analgesic, Talwin, (pentazocine) which is intended to reduce abuse of the drug combination "Ts and blues," (Talwin and Pyribenzamine) has been approved by the United States Food and Drug Administration. The product contains naloxone which does not interfere with the analgesic effect of Talwin but blocks the heroin-like effect.

World record?

LOS ANGELES — A 24-year-old woman here has smashed the world record for blood alcohol concentration and lived to tell about it. When admitted to hospital, the woman's serum alcohol was 1.5%, says an article in *Medical News*. The previous record appears to have been held by a 59-year-old man with a blood ethanol concentration of 1.12%. The woman had abdominal pain, nausea, vomiting, diarrhea, and a history of six to nine months of drinking up to 750 ml (26.8 oz) of hard liquor a day. However, she was well again 12 hours later and discharged in two days. Concentrations of .15% to .30% are usually enough to cause confusion, disturbance of balance and perception, and muscular incoordination. Potentially "fatal" level is .40% to .50%.

Nicotine and arousal

TORONTO — A dose of nicotine can cause a slump in a man's penile reactions to pornography, indicates a study carried out at Florida State University. Psychologist Richard Hagen found that when his male subjects smoked two high-nicotine cigarettes before watching erotic film clips, it significantly dampened their overall arousal (as measured by penile plethysmography). Eating candy had no such effect says *Modern Medicine* (January 1983).

Half and half

TORONTO — Diners are often asked nowadays if they want a table in the restaurant's smoking or non-smoking section. But visitors to the Wedgewood Restaurant here are more likely to be asked, "drinking or non-drinking section?" The restaurant lies on the border between the City of Toronto and the Borough of York and is "half wet and half dry." The "dry" half is in what once was West Toronto, where dry status has existed since 1903. The "wet" half is in the borough where the sale of alcohol is permitted.

Elderly alcoholics

WASHINGTON — A national alcohol research centre to study alcohol and its effects on the elderly will be established at the University of Florida. The university has been awarded a $405,000 grant from the United States National Institute on Alcohol Abuse and Alcoholism (NIAAA) to survey drinking problems among the elderly. Medical, behavioral, and social science researchers will investigate the prevalence, diagnosis, treatment, and prevention of alcohol disorders and related health problems. Such a research centre was authorized in the 1981 budget by Congress.

'Control-of-availability approach . . . will be a disaster'

Alcohol group favors education angle

By Harvey McConnell

WASHINGTON — A counter against the present thrust in many areas for tighter controls on alcohol is being made here by the Alcohol Policy Council (APC).

"We think the control-of-availability approach is the wrong one, and we favor the educational approach with an emphasis on responsible drinking," Augustus Hewlett, APC president, told **The Journal**.

Mr Hewlett was for many years executive director of the Alcohol and Drug Problems Association of North America (ADPA). He said he and James Peterson (PhD), director of the education commission of the states' task force which, in 1977, produced a report on responsible decisions about alcohol, became concerned about the "present climate" and put the council together.

They now have a 17-member advisory board drawn from across the field and have published three newsletters.

They believe heavy penalties, reduction in hours of sales or consumption, removing beer and wine commercials from television, raising the price of alcohol, and increasing the legal drinking age are approaches that would be counterproductive.

"We feel they simply reinforce the mystique around alcohol for young people, and there will be more, not less, furtive drinking on the part of young people. We favor the educational approach," Mr Hewlett added.

The council is looking for financial contributors and while "we would love" to get money from the beverage industry "we do not."

One hope is that people will recognize that the APC includes members from the alcoholism field who do not go along with the control-of-availability theories. Mr Hewlett said the council can go to the alcoholism field and point out that heavy controls will promote a condemnatory attitude to alcohol and alcoholics.

The emotional appeal of such groups as MADD (Mothers Against Drunk Drivers) can lead to a number of additional controls on alcohol, Mr Hewlett said. While "I have the utmost sympathy, as well as empathy, with the leaders of MADD, I believe some of their ideas are wrong."

Mr Hewlett said many have pointed out that no amount of controls will stop a determined alcoholic from drinking. "Thus we do favor the educational approach as the mechanism for reduction of alcohol problems, not a control-of-availability approach which we think will be a disaster."

Patients use narcotics for pain — not a 'high'

(from page 1)

said: "Morphine is a standard against which we compare all the new ones and there are not, certainly, any new ones which have shown up that well against it."

Kathleen Foley, chief, pain service at Memorial Sloan Kettering, and professor of neurology and pharmacology at Cornell, said the fact cancer patients can become tolerant to narcotics creates the confusion about physical dependence and addiction.

Dr Foley: "Physical dependence is an altered physiological state that is produced by repeated administration of the drug, and it is characterized by the appearance of the withdrawal syndrome.

"It is in marked contrast to addiction, which is a behavioral pattern for compulsive drug use and characterized by an overwhelming involvement in the use of the drug, in securing the supply of the drug, and a high tendency to relapse after withdrawal from the drug.

"Patients take the drug for pain and not for altered behavior. I think this is the important concept we have to use to convince doctors to understand that physical dependence, and psychological dependence and addiction, are separate entities."

Studies of US soldiers who served in Vietnam demonstrated that addiction is a more complex set of problems of behavior, circumstances, and pre-morbid personality.

Dr Foley said tolerance can clearly develop to a narcotic. When this happens, patients can be switched to an alternative in the hope they will not have the same degree of tolerance. "What one is trying to do is limit the pain and limit the amount of drug they are taking, rather than to escalate their drug."

Dr Foley and colleagues have observed that cross-tolerance is not complete "and one can switch patients from one narcotic analgesic to another narcotic analgesic and clearly get better efficacy."

In a study at Memorial Sloan Kettering of 45 patients who took a narcotic analgesic, 14 increased their dose to nearly double within a three-month period. Twelve of the 14 died within six months, and the increase in their drug intake was associated with progression of their disease.

Among the other patients, 11 decreased their intake of narcotics, and 17 remained stable and were able to maintain themselves, and, at the same time, received adequate analgesics. Three patients began taking narcotic analgesics during the study period.

Dr Foley said doctors in particular must be made aware that withdrawal from a narcotic is gradual.

An important issue which has not been addressed is the need for doctors to recognize that the patient who is tolerant to a narcotic analgesic is "exquisitely sensitive" to the introduction of a narcotic antagonist.

Patients have at times arrived at emergency rooms confused and disoriented. They were receiving large doses of narcotics for control of their cancer pain.

Unfortunately, the attempt by doctors to assess the reasons for their confusion and disorientation lead to the use of the antagonist, naloxone.

Dr Foley: "The problem is that in patients with the pain of cancer the use of the standard 0.4 mg per ml dose of naloxone is sufficient enough to have them sit up and scream in pain, and to develop rather profound psychotomimetic effects."

Dr Foley said such an occurrence is completely unnecessary. The use of naloxone this way "I think is both unreasonable and inhumane."

She said the 0.4 mg. dose of naloxone should be diluted in a 10 cc syringe and slowly administered to the patient, titrated against their respiratory distress.

Pain treatment question under study in Canada

OTTAWA — A Canadian report suggesting physician guidelines for all pain-killing drugs, including heroin, should be ready by late spring.

Ian Henderson, director of the Canadian bureau of drugs, says nine doctors chosen to study the issue will hear testimony during the next three months from world-renowned experts in pain management. (**The Journal**, Oct, 1982.)

The committee members are: Dr Gordon Bethune, chairman, Dalhousie University, department of surgery; Dr Louise Chevalier, Montreal Children's Hospital; Dr John Edmeads, professor of medicine, University of Toronto; Dr Robert Macbeth, executive vice-president, Canadian Cancer Society; Dr Paul Mitenko, professor of pharmacology and medicine, University of Manitoba; Dr Balfour Mount, director, palliative care unit, Montreal's Royal Victoria Hospital; Dr Ian Penderleith, head, medical oncology, British Columbia Cancer Control Agency; Dr Yves Quenneville, Notre-Dame Hospital, Montreal; and Dr Edward Sellers, clinical institute director, Addiction Research Foundation of Ontario.

The idea for the study followed a meeting last summer between Health Minister Monique Begin and Dr Kenneth Walker, who writes a syndicated column "The Doctor Game" under the pseudonym Dr W. Gifford-Jones (**The Journal**, Sept, 1982). Dr Walker presented the minister with more than 15,000 letters in support of legalizing heroin for medical use. (Canada banned heroin from all uses, including medical, in 1955 following a World Health Organization directive.)

Dr Walker has criticized the choices for the committee, claiming it's "loaded against heroin." He says some of the appointees have spoken out against heroin in the past and won't be objective in their deliberations.

Canada seeks vote

(from page 1)

Also seeking election are the Netherlands, Austria (since 1980 the home of the Vienna Office of the UN and several of its agencies and divisions), and Switzerland which, though not a member of the UN, as a signatory to the 1961 Single Convention on Narcotic Drugs, has a right to a commission seat. Sitting members up for re-election are Norway, Spain, Italy, the US, France, and the Federal Republic of Germany, some of them the strongest and most long-standing members.

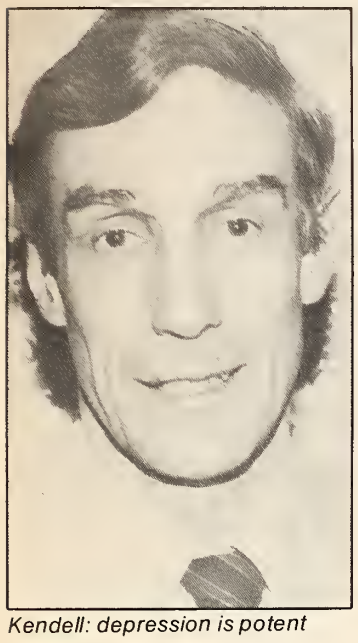
Although the approach to elections adopted in 1979 provides more representation on the commission for developing countries, it also carries with it the potential for a shift by the commission back to its former heavy emphasis on enforcement.

This reached its peak in the early 1960s with the dramatic upsurge in drug abuse in the west, particularly in the US, which believed essentially that if drug supplies could be wiped out, drug abuse in the US would end.

Its huge financial contribution to the UN (it provides 25% of UN's total annual budget) and massive bilateral aid to developing countries helped spread its philosophy. On the receiving end were often drug producing and transit countries where local drug use was also beginning to emerge as a serious problem.

The belief that the answer lay in strict law enforcement became well entrenched. Although it remains today perhaps the strongest current of thought at the commission, there is now another decided current of concern around demand reduction.

Many fear, however, that with the world in economic crisis, the attraction of the more immediate rewards of enforcement may once again shift the commission back across the line.



Kendell: depression is potent

Physicians fascinated by other effects

Suicide widespread among alcoholics

LOS ANGELES — The fact alcoholics have a very high suicide rate may be better known among laymen than physicians, says a professor of psychiatry at the University of Edinburgh.

Robert Kendell, MD, believes physicians tend to be preoccupied with the fascinating effects of alcohol on almost every tissue in the body.

"They see an enormous variety of clinical states; pathological lesions produced by alcohol affecting the heart, muscle, testes, the gastro-intestinal tract, a variety of cancers, and so on.

"But, in fact, most of these causes of death are much less important than suicide."

And, Dr Kendell says, the high rate of suicide among alcoholics would drop if alcohol consumption by the population as a whole declined.

"There's a lot of evidence from many different countries noting that most of the medical and social ill-effects of alcohol consumption, rise and fall with changes in the average consumption of the population as a whole."

Dr Kendell says anywhere from 10% to 40% of alcoholics commit suicide. The last few years have shown that suicide prevention programs and alcohol treatment programs have only limited effectiveness.

"Alcoholics' lives run into increasing trouble. They lose their wives, their jobs, their homes. They become lonely and isolated. They lose their self-esteem.

"They become depressed, and depression itself is very potent; it's a predisposal to suicide, as is social isolation in any setting, regardless of whether the subject is drinking or not.

"Intoxication itself makes them do silly things, do impulsive things, and perhaps even heavy drinking may cause depression by direct pharmacological means as well."

However, "if the population as a whole could be persuaded to drink less — then one could confidently expect that we would have fewer alcoholics and fewer alcoholic suicides," he told an international symposium on the psychobiology of alcoholism held here by the University of California at Los Angeles, extension department.

Dr Kendell acknowledges this is an unpopular approach because it affects business interests associated with the alcohol industry and the drinking habits of ordinary people. But it's the ordinary person who starts off as a social drinker and ends up an alcoholic who may commit suicide, he says.

Dr Kendell told **The Journal** the concept of alcoholism as a disease makes it convenient for the alcoholic. "It takes away main responsibility of the state he's in . . . (and) makes it the doctor's job to get him better."

It's important to remember that despite various theories, "what causes alcoholism is drinking alcohol," he says.

"And anybody who drinks enough for a long period is at risk of becoming dependent in exactly the same way as they are at risk of becoming dependent on heroin."

Britain committing £6m to fight drug addiction

By Alan Massam

LONDON — The British government will spend £6 million during the next three years to meet the challenge of rising-tide drug addiction here.

The move was announced in late January by Norman Fowler, social services secretary.

He said misuse of drugs has increased substantially. While Home Office figures suggest a 35% increase in notified addicts in 1980 to 1981, this is only the "tip of the iceberg." Research suggests 20,000 opioid addicts and 20,000 barbiturate and amphetamine misusers.

And the problem is not confined to young people. The elderly are dependent on barbiturates, and widespread use of tranquillizers is also causing concern, he said.

This multiple drug misuse is putting a strain on services set up in the 1960s to contain the rise in heroin addiction.

The rising figures are confirmed by notifications from family physicians treating drug dependent people. The rapid escalation has also involved some doctors who were inexperienced in recognizing drug misusers, and this has sometimes led to inappropriate prescribing.

Response to the increase will be multi-disciplinary, said Mr Fowler, and will cover training of specialists and non-specialists. He acknowledged that addicts are "difficult and demanding" and only likely to be helped by trained professionals.

MDs still miss alcoholism, help perpetuate the myths

TOLEDO, OH — Doctors are still failing to recognize alcoholism in their patients and an expert in the field pins the blame on faulty training.

Psychiatrist and head of the alcoholism treatment program at the San Diego Veterans Administration Hospital, Marc Schuckit says alcoholics typically present with a variety of physical and psychological complaints and are often hurriedly given medication for their symptoms. Then, they may go out and add alcohol to medication prescribed for the problem, and this continues the underlying pattern of alcoholism, he told the Toledo Academy of Medicine here.

Many doctors get into the habit of prescribing only for the immediate presenting symptoms because of their training, he claims. In public, veterans, and large city hospitals, the alcoholic is still viewed as "someone who comes into the emergency room at 2 am and vomits on your shoes." As a result, the myth of the alcoholic as a skid-row type is perpetuated, although these represent only a fraction of alcoholics.

Dr Schuckit admonished doctors to look for the much larger percentage of problem drinkers among patients who show such symptoms as excessive weekend drinking or absence from work because of drinking, but who otherwise behave as responsible family members.

Next month in The Journal

WASHINGTON — A significant reduction in marijuana use and a serious increase in cocaine and heroin overdoses in the United States between 1979 and 1981 has been found in surveys for the US National Institute on Drug Abuse (NIDA).

The findings are contained in the latest reports on household and high school surveys around the country. The surveys are carried out periodically for the NIDA.

Full reports next month.

The hero's drive home—in loving detail

By Wayne Howell

Ernest Hemingway used to put on reporters by claiming he was part native Indian. Indeed, he went so far as to conduct an interview with journalist Lillian Ross in comic, pseudo-Indian dialect, an interview that caused a scandal in literary circles when it was published in *The New Yorker* in 1950.

From the genetic point of view, the claim was nonsense, and from the cultural point of view, it was nonsense as well. Ernest Hemingway was the very archetype of the macho American drinker: he drank like a cowboy, not like an Indian. His object was to drink the other guy under the table and he had little respect for people who could not "hold it," that is to say, consume great quantities and act as if they had not.

As a teen-ager, he engaged in chug-a-lug contests with his friend Bill Smith. As a young man in Paris in the '20s, he continued to drink in a competitive manner and was disdainful of friends — such as F. Scott Fitzgerald — who couldn't hold it "like a man."

In his memoir, *That Summer in Paris*, Morley Callaghan describes the young Hemingway trying to bait him into a beer drinking contest in a Paris bistro, and Hemingway's smug superiority when Callaghan refused to take up the challenge and allowed Hemingway to best him, seven to three. In his megalomaniacal later years, one of Hemingway's favorite boasts concerned the night at the Floridita bar in Havana during which he consumed 16 double, frozen daquiris and was still able to make it home to his villa seven miles outside of town.

Making it home is an important part of the macho American drinking experience. You do not have to talk to very many latter-day, Hemingway-style drinkers to appreciate this. The drive home is described in as loving detail as is the drinking bout that preceded it: the wrong turns, the silly adventure in the shopping plaza, the nick given to the wife's car as our hero careens into his driveway, his last act before he staggers upstairs and passes out with his boots on.

The drive home is an essential part of the macho drinking experience. It is the final test of a man. The odds are against him: his eyesight is blurred, his reflexes are slowed, predatory police are out there waiting for him to make a wrong move. Yet he triumphs over adversity, both biological and societal, and lives to recount his tale on the morn, before awed contemporaries.

There is a profusion of literature about the problem of the drinking driver and what should be done about him. Very little of it seems to take cognizance of the fact that the drive home is really the last act of a three-act play. In the first act comes the drinking. In the second act comes the sexual adventure, or, failing that, the fight. The third act, the "denounement" if you like, is the successful drive home.

People who opt to play out this little drama are not going to be caught breathing into tavern-supplied breathtest machines. The very act would be an admission of incapacity, an admission that the ostensibly stiff upper lip has become pliable. That's just the kind of sissy thing you would expect women and homosexuals to do — two human groups Ernest Hemingway had little respect for. Nor are people who opt to play out this little drama likely to be deterred by announcements of police crackdowns.

The true measure of a man is to be found during the Christmas/New Year's holiday season. That is when the weak sisters and nervous Nellies show their true colors and opt for public conveyances of one sort or another. The macho drinker does not shirk from the challenge; he welcomes it as one more chance to show his grace under pressure. Making it home half-blotto on New Year's Eve is a tale worth more than one retelling.

Unfortunately, the third act of the aforementioned drama often ends in tragedy, not only for the protagonist but also for some bit-players who didn't even know they were in the play. To prevent these dramas, I think we have to look at why they occur in the first place.

It is ironic that if Ernest Hemingway were part Indian, as he claimed to be, he might not have adopted the drinking code that he did. Native Indians certainly have their own problems with alcohol, but those problems arise in good part out of cultural factors that are the very antithesis of Hemingway's cowboy drinking. Native Indians tend to 'show it' rather than 'hold it' and the showing of it is no cause for shame in the eyes of their peers.

In that, native Indians resemble cannabis users, whose pantheon of heroes is quite different from that of macho drinkers. In pot-smoking circles the man to be admired is the man who can get the highest on the least amount of psychoactive substance. He is admired if he admits he can't drive home after only one or two joints. It is sensitivity and responsiveness to the effects of the drug that are valued, not one's ability to persevere in spite of its manifest effects. (This is a world removed from the world of the macho drinker. Can you imagine one of the boys in a typical beer commercial admitting he was tipsy after just one or two brew? He might as well admit he likes to dress up in ladies' underwear.)

Most advertising campaigns directed against drunk driving appeal to reason, pointing out the chances of getting caught and the legal consequences that will befall. When they do appeal to emotion, it is to the drinkers' distaste of carnage, with illustrations of smashed vehicles. They don't get down to the subliminal heart of the matter — the culturally preconditioned drinking pattern that encourages the 'cowboy' to take on the drive home as a final challenge. It is conceivable that this type of well-intentioned advertising might actually be perceived as a red flag by the macho bulls.

If the 'cowboy' drinking mystique could be replaced by the 'Indian' drinking mystique, our highways might be safer places after dark. It is doubtful that such a change could be effected through advertising, but it might be worth a try, in view of the fact that advertising efforts to date have been rather unsuccessful.

There are ad-men aplenty who now spend their time dreaming up ways to 'macho-ize' brands of beer, and their success at convincing consumers that one brand (a brand that tastes essentially the same as all the others) is more manly indicates the power of subliminal persuasion. If their skills could somehow be harnessed in the interests of encouraging two-act dramas rather than three-act dramas, perhaps some good might result.

NEWS

RESEARCH UPDATE

Doctors seek rehab

A California program has shown impaired physicians can continue to practice while undergoing treatment. Since 1980, California law has allowed doctors involved with drug and/or alcohol abuse to be diverted from possible medical board discipline into the statewide treatment program; 138 doctors have participated as of last June. A review during the past two-and-a-half years said four key elements in the success of the California Diversion Program have been: a rapid response mechanism; an individual, tailored rehabilitation program; strict confidentiality; and frequent monitoring. Removal of the doctors' fear of legal discipline has resulted in the program's recognizing and treating doctors quicker, and most doctors now enter the program by self-referral. The review by Dr Anthony Gualtieri, Dr Joseph Cosentino, and Jerome Becker said 109 doctors in treatment have been able to continue to practice, and there have been no known examples of harm to patients.

Journal of the American Medical Association, Jan 14, 1983, v 249:226-229

Pot tops tobacco for tar

New work supports the hypothesis that smoking marijuana carries a health risk considerably higher than smoking tobacco because of exposure to tar. The study by William Rickert, Jack Robinson, and Byron Rogers compared two strengths of Colombian marijuana cigarettes with a standard tobacco cigarette. Analysis with an automatic smoking machine under standard conditions showed the marijuana cigarettes delivered an average of 38 mg of tar in comparison to 15 mg of tar delivered by the tobacco cigarette. Comparing marijuana, under conditions representative of how marijuana is used, and tobacco under normal smoking conditions, the marijuana yielded 3.8 times as much tar. A concern about variables affecting the different ways in which the substances are smoked led to an attempt to devise machine-smoking conditions that closely approximate real conditions. The researchers said this possibly made the study more reliable than earlier studies comparing tar yields.

Canadian Journal of Public Health, Nov/Dec 1982, v 73:386-391

Drinking and sudden death

A prospective study of more than 11,000 Yugoslavian men has found an inverse relationship between alcohol consumption and the subsequent appearance of coronary heart disease seen as myocardial infarction or non-sudden coronary heart disease, but a direct relationship between recent drunkenness and sudden cardiac death. The re-examination of the Yugoslavia Cardiovascular Disease Study by Yugoslavian and United States researchers found urban men who drink most frequently had half the subsequent incidence of overall coronary heart disease that men who seldom or never drank did. This inverse relationship was statistically significant even after taking into account differences in blood pressure, serum cholesterol levels, cigarette smoking, and other variables. The specific association of drunkenness and sudden death suggested to the investigators that the acute effect of heavy drinking may be a dominant factor in the incidence of sudden death in the group studied.

American Journal of Epidemiology, Nov 1982, v 116:748-758

Drinkers do fine in narcotic rehab

Alcoholism does not significantly affect rehabilitation from narcotic use and should not be cause for detoxification from methadone maintenance, a study of 625 patients in methadone therapy in New York City indicates. In a randomized single-blind trial by researchers from Mount Sinai School of Medicine, City University, New York, patients were categorized by their alcohol consumption, and the influence of alcoholism on the rehabilitation process was assessed. The team found alcohol consumption "did not interfere significantly with therapeutic efforts recognized for rehabilitation from narcotic dependence." Alcohol consumption diminished in all patients in the methadone maintenance program with the greatest decrease in those initially characterized as active alcoholics. In psychosocial function, productive activity, and illicit drug use there was no difference between the active alcoholics and other patients.

The American Journal of Medicine, 1982, v 73:631-635

Relapse patients face depression

Patients discharged from alcohol or drug abuse treatment who do not relapse have a rate of depression no higher than the general population. But with patients who do relapse, the rate and severity of depression is significantly higher. These were the findings in a University of Minnesota study where 842 alcohol and drug abusers were followed at either one, six, or 12 months after discharge from a private inpatient alcohol or drug dependency treatment facility. Questionnaires were used to gauge the patients' rate of depressive symptoms. Women were found to be more depressed than men after treatment, but the ratio of depressed women to men was no higher than that found in the general population. Dorothy Hatsukami and Roy Pickens said the rate of depressive symptoms in the abstinent group ranged from 8.3% to 15.2% as compared to a range of 7.5% to 13.4% in the general population and a rate of 22% to 33.3% in the relapsed group.

American Journal of Psychiatry, Dec 1982, v 139:1563-1566

Pat Rich

Ottawa aid to disadvantaged helping alcoholics find jobs

By Mark Kearney

OTTAWA — More than 240 recovered alcoholics have found jobs in the past two years with help from the federal government Program for the Employment Disadvantaged (PED).

Under the PED, the employment and immigration ministry has placed more than 8,300 disadvantaged people in jobs. Of these, 2.9% were recovered alcoholics, says program manager Suzanne des Rivieres. Another 0.8% had recovered from other drug addictions.

The ministry works closely with local employment centres and social service agencies to determine who qualifies for the program. The service group decides who is or is not a recovered alcoholic.

Ex-inmates, native people, women returning to the labor force, youth who have never held a job, and welfare recipients also qualify for assistance under the program, as well as another 8,000 who are physically or mentally handicapped, Ms des Rivieres says.

The PED pays employers 85% of gross wages for as many as 13 weeks to hire an employment-disadvantaged person in a continuing job at the going rate. After that, wages can be subsidized at 50% for up to 13 weeks, and 25% for a further 13 weeks.

People are eligible if they have been looking for work for 20 of the past 26 weeks, or for at least five weeks if they are mentally or physically handicapped and would not likely find jobs otherwise.

"This program was specifically tailored to reduce hiring barriers for those who need help the most," says Ms des Rivieres. "The generous funding is an incentive for employers to hire people they might not otherwise consider.

"It's available for a fairly long time so as to cover what might be a difficult breaking-in period for new employees while they are getting integrated on the job."

Response from employers has been overwhelmingly favorable, she says, and some local officials who have helped with placements call it the best idea the government has come up with to battle unemployment.

However, Ms des Rivieres says the biggest challenge is still convincing employers to take a chance on the disadvantaged.

"They're our best advertisers. Once they hire someone through the program and are satisfied, they pass the word."

The ministry is planning a survey of employers, workers, and community groups who have been involved with the PED to determine how well it's working, Ms des Rivieres says. Results should be available in the summer.

The program's budget was $48.2 million for the 1982-83 fiscal year and that will rise to $51.5 million in 1983-84. However, the increase is specially geared toward handicapped people and severely-disadvantaged youth.

'Jump-out squads' in DC keep street dealers wary

By Harvey McConnell

WASHINGTON — Tough and rough special "jump out squads" of District of Columbia police have had a visible impact in curbing street-corner drug dealing here.

The special 34-member task force set up by Police Chief Maurice Turner 18 months ago has made more than 4,000 narcotics-related arrests. In addition to drugs, the officers have confiscated more than 120 guns, 13 cars, two vans, a motorcycle, and $175,000 in cash.

They are called "jump out squads" because when an undercover agent spots a drug dealer, he signals an unmarked cruising police car, and three to five policemen jump out to make an arrest.

Police are not claiming the squads have had a major impact on overall drug dealings in Washington. But they have certainly stopped open dealing in particularly notorious areas, such as 14th and U streets northwest.

Chief Turner commented: "People were selling all kinds of drugs out in the open, an obvious detriment to the quality of life in the city. I think our unit has had a tremendous impact on reducing that."

Supreme court to decide

Reverse onus provision challenged

TORONTO — It is unconstitutional to presume a person found with illegal drugs is trafficking in them, the Ontario Court of Appeal has ruled.

The Appeal Court says Canada's Charter of Rights and Freedoms protects an accused person from having to prove he did not intend to traffic in a narcotic found in his possession. This is the first appellate court ruling in Canada on this issue.

An application to appeal the decision to the Supreme Court of Canada is scheduled for March 21. If the leave of appeal is granted it could be at least another six months before the case is heard again, says Crown Counsel Michael Dambrot of Toronto.

"Mere possession of a small quantity of a narcotic drug does not support an inference of possession for the purpose of trafficking, or even tend to prove an intent to traffic," the Ontario court says.

The section of the Narcotics Control Act, called "reverse onus," requires the Crown first prove beyond a reasonable doubt that the accused was in possession of a narcotic. The onus then shifts to the accused to disprove the trafficking charge on a balance of probabilities.

The reverse onus section has been one of the most frequently raised issues since the Charter of Rights came into effect in April, 1982. The presumption of innocence of the accused is entrenched in section 11(d) of the Charter (**The Journal**, Sept, Oct, 1982).

At least six judges across Canada have upheld the reverse onus section, while a similar number have ruled it unconstitutional.

The special five-man Court of Appeal upheld a decision by a London, Ont, Provincial Court judge who found a 24-year-old unemployed construction worker not guilty of trafficking in eight one-gram vials of hashish oil on the ground the reverse onus section was unconstitutional.

"Manifestly, a reverse onus provision placing the burden of proof on the accused with respect to a fact which is not rationally open to him to prove or disprove cannot be justified," the court says.

Drivers in Minnesota get DWI message at the pumps

ANOKA, MN — Drivers now get more than gas when they pull up to the pumps in this state.

They get stern messages about the consequences of drinking and driving too, thanks to a campaign to publicize tougher state laws passed in 1982 to cut drunk driving.

The campaign was launched in January by the Minnesota Institute and its state-funded project, the Minnesota Prevention Resource Center. It consists of three poster messages displayed on gas station pumps.

Richard Neuner, executive director of the Institute and creator of the poster idea says the posters emphasize the apprehension aspect of drunk driving because drivers respond better to the perception that they're likely to get caught than to other counter-measures.

Using gas pumps as an advertising medium hasn't been tried before in the United States, says Mr Neuner, and, because it's new, drivers will pay attention.

In addition to the novelty of the medium, advertising on pumps has the advantage of directly connecting the message to driving and getting it across several times a week.

NEWS AND COMMENT

US fielding more anti-drug forces despite criticisms

By Harvey McConnell

WASHINGTON — Agents and prosecutors have been assigned to 12 regional anti-drug trafficking task forces across the United States amid reports internal bickering seriously weakens administration anti-drug efforts.

US Attorney-General William French Smith said 18 agents drawn from the Federal Bureau of Investigation (FBI), Drug Enforcement Administration (DEA), Internal Revenue Service, Customs Service, and the Bureau of Alcohol, Tobacco and Firearms have been assigned to each task force along with four prosecutors.

The anti-drug task forces, modelled on the successful task force in South Florida (**The Journal**, April, 1982), are expected to have 1,200 agents and 400 prosecutors when they reach full strength.

Mr Smith said each task force will have two major cases to investigate initially. He added "all of these cases will be what our investigative agencies define as high quality ones — those involving major trafficking by major organized crime groups."

At the same time, the attorney general, in an obvious reference to a leaked report by the General Accounting Office (GAO), an arm of Congress, said there is no basis for any kind of complaint about cooperation among the various agencies. "Anyone who's saying that doesn't know what he's talking about."

The GAO report rapped federal drug law enforcement accomplishments during the past few years. It said figures from the DEA, for example, show only 5% of the defendants arrested by the task force in Florida are considered major violators. In addition, at times the same seizure has been counted as a major haul by differing agencies.

There has always been — and continues to be — friction among competing agencies such as the DEA and FBI, and the customs service and the coast guard, even though they have all been drawn together in the anti-drug fight.

Assistant Attorney-General Rudolph Giuliani claimed the GAO report was full of errors and had been released prematurely by both the GAO and a Democratic senator, both of whom favored a proposed bill trying to set up a "drug czar" who would oversee everything.

US President Ronald Reagan vetoed the "drug czar bill" because the administration felt it would only add another layer of bureaucracy.

Smith: high quality cases

GILBERT

'. . . a low budget affair . . .'

Britain's Addiction Research Unit

By Richard Gilbert

What is happening in other places? Researchers' contacts are chiefly with individuals working on problems closely related to their own. A synoptic view of an institution's endeavors might be interesting and useful. With this in mind I spent an afternoon while in Britain recently at the Addiction Research Unit (ARU), located at 101 Denmark Hill in London, some 5 km south of London Bridge, and 2 km east of Brixton (of race riot fame).

The ARU has been Britain's main centre for research into drug abuse since it was established in 1965. It is a low-budget affair, surviving on the equivalent of roughly $1 million a year. Ontario's Addiction Research Foundation (ARF), by comparison, spends more than $7 million of its $25 million annual budget on research. This does not mean that the ARF is profligate in its spending. Average salaries are higher in Canada; overheads are greater; the scope of the research is wider at the ARF; more people are engaged in research; and total output is greater than at the ARU.

I have heard researchers at the ARF speak wistfully of working as part of a small, dedicated, focussed, and autonomous group. The ARU is the stuff of which such dreams are made. Its dozen or so researchers and slightly more support staff work in close intellectual and physical proximity in a cramped building that looks as if it was constructed to meet a forgotten emergency.

Formally the ARU is part of the department of psychiatry within the Institute of Psychiatry, which is a post-graduate medical institute of the University of London. The ARU is physically a part of the Maudsley Psychiatric Hospital. The director of the ARU, Griffith Edwards, is also the director of the Addiction Treatment Unit at the Maudsley and professor of addictive behaviours at the Institute of Psychiatry.

Two parts

The work of the ARU falls naturally into two parts, each consuming about half the total budget. I'll describe the work on smoking next month, with a particular emphasis on investigations into the effectiveness of nasal nicotine solution (ie, liquid snuff) as a substitute for tobacco use.

This month I want to write about the ARU's other work, which is almost entirely on alcohol abuse.

Griffith Edwards' main interest is in the careers of alcoholics. On the practical side this consists of a 10-year follow-up of 100 drinkers, but he is more occupied with clarifying the concepts of career on the one hand and natural history on the other.

By 'careers of alcoholics,' Edwards has in mind the familiar concept of an unfolding sequence of individual behavior related to individual fulfilment, a sequence that may be describable in phases and may be said to have normal and deviant routes. An alcoholic career consists of the social and behavioral aspects of excessive alcohol use in time.

The natural history of excessive alcohol use consists of the changes in reactivity to alcohol in time, chiefly increased tolerance and dependence, but also other alcohol-induced changes such as brain and liver damage.

Ultimately, says Edwards, there is only one set of phenomena, but for the present it is necessary to emphasize the two perspectives — behavioral change in time and physiological change in time — because researchers interested in long-term changes tend to focus on one or the other.

Priming

The other main researcher on alcohol abuse at the ARU has been Ray Hodgson, who will have left for a clinical position in Cardiff, Wales by the time this column appears. Hodgson has focused on the notion of dependence, and specifically on the way in which a drink can evoke craving for alcohol. Such a priming effect is one of the two dogmas of Alcoholics Anonymous, which holds firstly that alcoholism is an incurable disease, and secondly that sufferers from the disease must abstain from alcohol because one drink will arouse (prime) their latent craving for the bottle, cause them to lose control over their drinking behavior, and set them sliding on the slippery slope to disaster.

When Hodgson began his work in this area in 1974, there was almost no experimental evidence of priming. His first study provided some evidence, but only in severely dependent patients, and only from one of the two tests he used.

The test that provided evidence consisted of recording the time elapsing before the first drink was taken when an alcoholic drink was made available some hours after a priming drink or drinks. Subjects rated as severely dependent reached for a drink with significantly greater alacrity if they had had six priming drinks than if they had had one or none. Moderately dependent subjects showed, if anything, an opposite effect.

The other test was a desire-to-drink test in which the subjects responded to descriptions of their affective states (ie, reported their craving) by marking a scale ranging from 'not at all' to 'very strong.' Neither group of subjects showed a priming effect on this test.

The next study sought to discover if this priming effect could be enhanced by the presence of a full bottle of vodka during the period between priming and testing. It was, but Hodgson also found that repeated exposure to the procedure reduced the effect. The bottle was explained to the subject (all inpatients in an alcholism treatment unit) with the phrase "treatment requires that you resist drinking," and, it seems, the basis for a useful treatment procedure was chanced upon.

This attenuation of the priming effect by exposure (but not access) to alcohol is now being studied in a controlled trial. If the trial is positive, British pubs may very well become the haunts of recovering alcoholics, sitting proudly by their vodka bottles, nurturing soda water as their resistance rises.

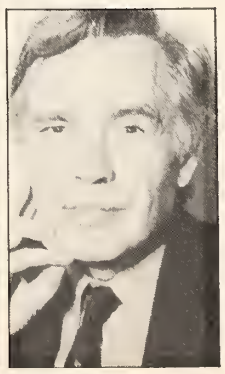
Differences

One question about the priming effect, such as it is, is whether it is caused by the actual consumption of alcohol or results from the belief that alcohol has been consumed. Using the procedure developed by Alan Marlatt (**The Journal**, Sept, 1975) — who found that people drink according to whether they think they are getting alcohol, rather than whether they are receiving it — Hodgson and his colleagues studied what happens when the priming drinks contained no alcohol, even though the subjects were led to believe they did.

They found that priming in severely dependent subjects was influenced mostly by the amount of alcohol taken. The modest priming effect evident in the moderately dependent subjects, on the other hand, seemed mostly affected by what they believed they had been drinking.

What this has led to, of course, is a deeper consideration of the differences between severely and moderately dependent alcoholics. For the purposes of the various investigations, the distinction was made chiefly on the basis of the frequency of reported incidents of withdrawal symptoms. Now, it seems, manifestation of phobic reactions provides a reliable means of distinguishing the two types of patient. The severely dependent patient has more phobias, and these phobias get worse during binges, unlike the few phobias of the moderately dependent patient, which seem to remain unchanged in intensity. A behaviorist might want to know why the frightening experience of the phobias during binges would not deter the severely dependent drinker, but the same kind of question could be asked about many other aspects of the heavy drinker's life.

Hodgson



Edwards

This work will be carried on by Tim Stockwell, who has been Ray Hodgson's collaborator on much of what has already been achieved.

Three other researchers are working on alcohol problems at the ARU. Gloria Litman is studying how non-drinking alcoholics go about trying to avoid a relapse, and how treatment helps them stay away from the bottle. The core of her work is a prospective study of 160 patients whose coping strategies are being examined by interview before and after treatment and one year later.

Evaluation

Betsy Ettore is a sociologist evaluating the 33 alcoholism treatment units (ATUs) in Britain. I did not meet her, but was told she is asking questions such as the following: Do patients of the ATUs improve because of the treatment they get? If not, do the ATUs provide other benefits to society? Can their cost be justified in terms of either kind of benefit? If none of the questions can be answered affirmatively, what political considerations support the continued existence of the ATUs?

Carol Smart is attempting to study the forces bearing on the evolution of the drug policies of the British government. An important part of her data consists of interviews with people who were central to the various decisions that have been made — mostly senior bureaucrats. What has emerged so far is considerable divergence of views as to what actually happened in particular instances.

Nightly scene

The only person not working on alcohol or tobacco problems at the ARU is Angela Burr, the unit's first anthropologist. Burr appears to spend much of her time mingling with the nightly drug scene at Piccadilly Circus, home of the Eros statue and an all-night drug store. She has noted that the scene's actors are mostly chronic drug users of working-class origin (a more meaningful label in Britain than in Canada or the United States) who are as much interested in being part of the Piccadilly Circus scene are they are in drugs.

On scrutiny the scene's apparent chaos becomes defined as a kind of open market for the buying and selling of surplus prescription drugs, mostly methadone, Ritalin, amphetamines, and barbiturates, with very little heroin for sale. A first report will be published in the *British Journal of Addiction* (BJA) in June.

Finally, I should note that producing the BJA is an important enterprise of the unit. Griffith Edwards is editor of the BJA, with Ray Hodgson (soon to be replaced by Tim Stockwell) as his deputy.

Next month: Smoking research at the ARU.

NEWS

SMA wants limits on blood-alcohol test proposal

Patient care, not policing, MDs prime role

By Mark Kearney

SASKATOON — The quality of medical care could suffer if police here are allowed to demand quick blood samples from drivers involved in accidents, says the Saskatchewan Medical Association (SMA).

Ernie Baergen, the SMA's executive director, says the proposal before the Saskatchewan legislature is intended to help police detect impaired drivers. However, it could also mean that taking the sample is more important than treating the patient.

"We're saying to the government 'hey, don't go that far," Dr Baergen told **The Journa**l. "It could take it too far and emphasize law enforcement over medical care."

The SMA supports the government's intentions under the proposal, he says, but wants to make sure it's done safely and properly.

The proposed change in the province's Vehicles Act is an attempt to solve the problem faced by police, who are unable to obtain breath-alcohol samples until after the diagnosis and treatment of injuries, which might take several hours and render samples useless.

The proposal calls for blood samples to be taken by medical personnel, who would be given legal protection to do so under the act.

Dr Baergen says the SMA applauds the move to give doctors legal protection but questions the need for quick blood samples before treatment is completed.

He believes the samples shouldn't be useless when taken later if there is a method to determine the rate alcohol is metabolized into the system. What's important is that the person receive proper care, Dr Baergen adds.

The government also proposes it be mandatory for doctors to report the condition of a person unfit to drive, including those impaired by alcohol, he says. The SMA opposes that because doctors shouldn't be obliged to report on patients under threat of law.

The proposals, contained in a white paper, come on the heels of a recommendation last year by the Canadian Medical Association (CMA) to allow doctors to take blood samples from impaired drivers without their consent (**The Journal**, Nov, 1982)

Dr Baergen says his association supports the CMA stand but adds there is some concern about possible human rights violations.

Federal officials are currently studying the idea and possible changes to the Criminal Code. However, some criminal lawyers and civil libertarians say the move would infringe on the confidential relationship between patient and doctor and put doctors in a law enforcement role.

The Saskatchewan proposal may be debated in the legislature as early as this spring, but Dr Baergen says the government has yet to respond to the doctors' concerns.

DWI campaigns pay off in west

By Rhonda Birenbaum

OTTAWA — Campaigns to discourage drinking and driving, instituted in British Columbia and Saskatchewan, appear to have had significant, positive effects.

Since 1974, when these two provinces began "strong" anti-drinking-and-driving campaigns, (**The Journal**, Feb, 1976) there has been a notable decrease in the number of impaired drivers on the roads there, according to a 1981 survey by the road and motor vehicle traffic safety branch of the federal Department of Transport (DOT).

In BC the number of drivers on the road with blood alcohol levels of 75 mg/100 ml (0.075% — chosen to match with international convention) or more dropped to 6.1% in 1981 from 7.8% in 1974. Comparably, in Saskatchewan, 15.9% of drivers were impaired in 1981, down from 20.7% in 1974.

In contrast, more impaired drivers were on the roads in Quebec during the 1981 survey: 7.0% vs 5.3% in 1974. It did not take as strong a stand against drinking and driving as the western provinces, said John J. Lawson, associate director of the study.

These results are based on a night-time survey conducted in the three provinces and involving a total of 26,665 drivers (9,751 in 1974 and 16,914 in 1981). Drivers were randomly stopped between 9 pm and 3 am on Wednesday to Saturday nights, asked to voluntarily supply a breath sample and answer a questionnaire providing information on driver sex, age, vehicle type, trip length, and use of seat belts. From the data, Mr Lawson and his DOT team created a composite description of impaired drivers.

In all three provinces male drivers were much more likely than female drivers to be impaired, he told the annual meeting of the American Association for Automotive Medicine here. Males constituted between 77% and 97% of impaired drivers.

The three regions also showed similar statistics regarding seat belt use. "Blood alcohol levels were consistently higher among non-wearers," Mr Lawson said. "Sixty-four per cent (of impaired drivers) were unbelted in BC and Quebec, and 40% were unbelted in Saskatchewan."

Driver age differed in the provinces surveyed. In Saskatchewan, there were more impaired drivers in the 16 years to 24 years age group; while in BC and Quebec, most impaired drivers were 25 years to 39 years old. Nonetheless, Mr Lawson found the youngest drivers still made up a significant proportion of those impaired: 43% in Saskatchewan, 38% in BC, and 27% in Quebec.

Saturday night was most popular for drinking and driving in BC. Thursday night provided the highest proportion of impaired drivers in both Saskatchewan and Quebec. However, regardless of the night or province, the proportion of impaired drivers increased from an average of 2% at 9 pm to an average of 12% by 3 am.

Alcohol-impaired drivers are major contributors to road casualties and have prompted strong counter-measures throughout Canada.

Anti-smoking efforts 'weak-kneed'

By Jane Wilson

TORONTO — The silence of three major Canadian health agencies on the need for legislative controls on the tobacco industry is "scandalously negligent," says Garfield Mahood, executive director of the Non-Smokers' Rights Association here.

In a virulent attack, Mr Mahood has criticized the Canadian Cancer Society, the Canadian Heart Foundation, and the Canadian Lung Association for spending much of their time and energy on a "weak-kneed" public education campaign which "trivializes" the efforts to eliminate smoking.

The agencies should also turn off the tap on some research aimed at curing cancer, he said at a press conference here.

"The overwhelming preoccupation with research gives people who smoke a false sense of security. It encourages them not to take responsibility for their health; they figure sooner or later someone will find a cure for lung cancer, so I'll continue doing what I'm doing," he told **The Journal**.

Mahood: scandalously negligent

Major efforts such as National Non-Smoking Week and Weedless Wednesday, sponsored by the national organizations fighting cancer, heart disease, and lung disease, are "not good enough," Mr Mahood said.

The campaign must include aggressive demands for legislation to ban tobacco advertising and promotion, to regulate the industry, and to protect non-smoking workers in public places and at work.

Legislative changes could include:

- Provincial statutes introducing clean air standards for indoor areas and guarantees that non-smoking workers would not be subjected to second-hand smoke;
- A phased-in ban on all forms of tobacco advertising and promotion, including sponsorship of sports and cultural activities;
- Restrictions on the distribution of tobacco products to reduce the opportunity for people to buy cigarettes and make them more difficult for children to buy;
- Federal health regulations to force tobacco companies to disclose the contents of cigarettes, including additives; and,
- Increases in tobacco taxes should be tied to the Consumer Price Index or any additional revenue should be channeled into health care so the government does not become "addicted" to the tax revenue as part of its budget, he said.

For the past 20 years, health studies in the United States and Canada have repeatedly called on legislators to regulate the tobacco industry, but "there has not been a single statute or regulation directed at the smoking problem passed at the provincial or federal level in Canada in over 50 years," Mr Mahood said in a written statement endorsed by 12 doctors, academics, and businessmen.

The latest study was a 1982 report by the task force on smoking and health which was presented to the Ontario Council of Health. The task force asked the province to double the price of cigarettes through taxes and prohibit all forms of tobacco advertising (**The Journal**, Oct, May 1982).

"During National Non-Smoking Week (in January) you hardly hear a whisper or perhaps nothing at all from the sponsors about demands for legislation to deal with the horrendous (disease and death) rates associated with smoking," Mr Mahood said. About 35% of Canadian adults smoke, a decrease of 10% in the past 15 years.

Gerbils start secret prison work after months-long technical delay

By Mark Kearney

TORONTO — The gerbil patrol has overcome a seven-month delay caused by equipment failure and is now sniffing out drug smugglers at an Ontario prison.

The Correctional Service of Canada announced last year a $60,000 experiment using gerbils to sniff out illegal drugs being carried into or out of prison (The Journal, **July 1982). The project was to have started last June.**

However, Dennis Finlay, the service's chief of media relations, told The Journal **the project was delayed because the apparatus in which the gerbils are placed when performing their task was damaged in transit from Toronto.**

Despite the setback, the gerbils have now been trained and put to work, he says. When the program was announced, the service had chosen Warkworth Medium Security Institution in Campbellford, Ont as the site of the experiment.

However, Mr Finlay says a new prison has been chosen. To ensure the smugglers don't know where they might be detected, he won't name it.

Trained to detect drugs

"Any information an inmate gets he can use, and they (prisoners) read newspapers and journals and listen to the radio just like anyone else."

No time limit has been set on the experiment, but Mr Finlay expects it will take from three to six months to determine the gerbils' success.

Animals known for their keen sense of smell, the gerbils have been trained by a Toronto firm. They are hidden near the entrance to the prison, and push a lever activating a light if they detect drugs on prisoners or visitors as they arrive or leave.

Gerbils are relatively inexpensive to keep, can be trained, and have a good sense of smell. The burrowing rodents have been used by customs and excise officials in the past to detect drugs being smuggled into the country at airports, Mr Finlay says.

Med students smoke less than peers

TORONTO — Medical students are healthier and smoke less than their non-medical counterparts, says a study from the University of Tennessee in Memphis.

The study found that only 10% to 12% of those surveyed at three United States medical schools reported smoking compared to 30% to 40% in a statistically matched age group, says an article in *The Medical Post*. Medical students also had lower blood pressures and serum cholesterol levels than the US national average for their age.

However, Dr S. Edwards Dismuke of the university's departments of community and internal medicine, says that as med students become seniors their health habits fall off slightly.

"For example, we observed a higher cigarette and alcohol consumption in seniors. The frustrations and demands of medical school probably account for this change in health habits by the senior year," he says. The study was presented at the American Heart Association meeting in Dallas.

Ban drug users for life amateur athletes say

By Mark Kearney

OTTAWA — Only a small minority of Canada's top amateur athletes use performance-enhancing drugs, says a survey by the Sport Medicine Council of Canada.

However, the council's executive committee recommends stricter enforcement against drug violations and more educational programs to make athletes, coaches, and medical practitioners more aware of the International Olympic Committee's (IOC) doping control regulations.

The survey began last July and was the first attempt in North America to quantify the extent of drug use in amateur sport.

Patti-Jo McLellan Shaw, the council's program coordinator, says the survey's results show about 5% of the athletes use anabolic steroids to enhance performance. Use of other drugs was too low to be statistically significant.

She says the findings of the survey are "severely limited" because only 33% of 1,687 athletes, coaches, and practitioners responded. Only a 20% response was needed to draw conclusions, but the council wanted as clear a picture as possible of drug use in amateur sports, Ms Shaw adds.

There was also a disappointing response from athletes in sports where steroid use may be more widespread, such as track and field or weightlifting, she says, but the council has no way of knowing whether a higher response rate would have changed the percentages significantly (**The Journal**, Aug, 1982).

"I'm glad the survey was done because now you know what you're dealing with," Ms Shaw told **The Journal**. "We know it (drug use) is a problem in some sports, but overall it's a minority of athletes."

She says that while there were no surprises in the findings, it's important that those directly involved in amateur sports, and not just the government bureaucrats, have a say in any decisions made.

For example, most of the respondents didn't believe the regulations about use of drugs were strict enough and favored a lifetime ban on those caught breaking the rules, Ms Shaw says. However, there is still a need for more education because 81% of the athletes, 48% of the coaches, and 51% of the practitioners hadn't read the IOC's doping control regulations.

Most amateur athletes believe regulations about use of drugs should be more strict, Sport Medicine Council says

The survey's findings and the council's recommendations are now in the hands of Sport Canada. However, Ms Shaw says it's difficult to say if anything will be done this year because of a possible shortage of money.

Ms Shaw says until now there were suspicions that only a few athletes were using drugs, but most of the information was "anecdotal" instead of factual.

Amateur sports, especially at the Olympic level, have been plagued in the past by reports of athletes using a variety of drugs to improve performance. Canadian officials say the problem is much more common in Eastern European countries than here, but there is a need to ensure it doesn't worsen (**The Journal**, Feb, 1979).

One result of the survey may be more widespread use of drug testing at athletic events, Ms Shaw says, but at $100 to $200 per test, the costs may be prohibitive.

The council has recommended that Canadian officials press for more international cooperation in enforcing doping regulations.

Study spots profound physiological changes

Even one day off cigarettes helps

By Austin Rand

TORONTO — Moderate and heavy smokers exhibit a number of physiological and behavioral changes after one day without cigarettes.

So say Addiction Research Foundation researchers Richard Gilbert, PhD, and Marilyn Pope (**The Journal**, Aug, 1982). The study was published recently in *Psychopharmacology* (1982, v 78: 121-127).

The team undertook the research to increase the "sparse information" available on the changes that occur on the first day that the dedicated smoker does without tobacco. Each subject in the study — which involved 10 men and nine women — smoked at least 20 cigarettes per day and had no intention of quitting.

For the experiment, each subject spent one supervised 24-hour period without smoking and another supervised period with access to cigarettes. During both days, each subject underwent 25 "probes," one every 30 minutes from 8 am to 8 pm.

Each probe consisted of measuring pulse, skin temperature, and hand tremor, and asking the subject to indicate, on a scale running from 0 to 100, how much he or she wanted a cigarette.

The subjects' food and alcohol intake was also carefully monitored on both days.

The researchers found that finger temperature was on average more than 1^0C higher on the non-smoking day (implying better circulation, they note), while the pulse averaged at least five beats less per minute, implying less stress on the cardiovascular system. At the end of the non-smoking day the average pulse rate was 64 b/p/m compared to 74 b/p/m at the end of the smoking day.

Average hand-tremor was also significantly less on the non-smoking day.

On the negative side, subjects' calorie intake jumped by 10% on the non-smoking day, with the subjects actually eating less during meals but more in the way of snacks. Men's calorie intake from snacks rose 50% and women's jumped 94%. There was, however, no evidence of any increased inclination to eat sweets on the non-smoking day.

The "craving index," indicating how much the subjects wanted a cigarette, rose steadily during the course of the non-smoking day, jumping with each meal and peaking in the evening at about "70" — indicating a fairly intense desire for a cigarette.

When the subjects were finally allowed to have a cigarette, at the end of the non-smoking day, only four of the 19 described it as "pleasant." Six described the first cigarette as "unpleasant" and many felt dizzy or light-headed from the cigarette.

"Females seemed to find their first cigarette after abstinence to be less agreeable than males (did).

"Quitting brings about profound changes in a smoker's physiology and behavior, even during the first day. Anticipation of these changes could help would-be quitters and those who advise them" they conclude.

Substance abusers 'getting high on wellness'

By Lynn Payer

TOPEKA, KS — The alcoholism unit at the Menninger Foundation here tries to get patients addicted — to physical fitness.

Addiction to fitness may be attractive to some

Raising the possibility that substance abusers may be more prone to "fitness addiction" than other individuals, Robert W. Conroy, director of the unit, told **The Journal** "the potential payoff is enormous. We hope they can get a high on wellness rather than on illness."

Whether the patients become addicted, Dr Conroy says the program meets two important needs of substance abusers. "They need to be physically reconditioned, and they need to be reacquainted with leisure time."

Interest in physical fitness as therapy predated his appointment as director of the unit in Sept, 1982, Dr Conroy says. While working with psychiatric patients at the foundation, he explains, he had shown exercise programs significantly help alleviate patients' depression.

Dr Conroy and other staff say the fitness program will be even more valuable in the alcoholic and drug abuse patients, partly because they tend to be younger and, once substance abuse stops, in better physical shape, and partly because they are mentally healthier than the psychiatric patients.

The exercise program itself, says Valerie Walker, (RN), coordinator of the fitness program, is based on the Cooper point system, in which different kinds of physical exertion are translated into a certain number of points. Each patient undergoes a physical examination before the program, and the exercise is tailored both to the individual and, to some extent, to the group of patients.

"An all-male group will not do aerobic dancing," Ms Walker said, although the choice does not keep patients from complaining. "Everyone in all my classes always complains about the exercise."

Because the staff believes a certain intensity of exercise is necessary before it becomes addictive, the program is reasonably intense. Staff members must support the program, at least in spirit, but they are also encouraged to participate in the exercises.

Patients are also given nutritional information and vitamins.

Dr Conroy admits it is too early to assess what effect the exercise will have on the patients' alcoholism or other substance abuse. Improvements in physical condition become apparent in five weeks, he says.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

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Alc/drug classes for youth have immense potential

The article by Mark Kearney "Alcohol classes keep teens off court dockets" (**The Journal**, Sept, 1982) has really stimulated my interest. The Newton (Ma) Youth Alcohol Program has immense potential where various systems and disciplines can be integrated effectively.

It is an indication to teenagers that not only their parents, but the education system, judiciary, and social welfare services take a keen interest in their well-being and development. By seeking alternatives other than jail, the teenagers are given the chance to improve their knowledge and broaden their social perspectives.

As a tertiary prevention method the alcohol/drug classes will render them the opportunity to become responsible citizens, whose inherent potential can be channelled to establish a society based upon mutual trust.

It is basically vis-a-vis a community service order, with the difference that the incentive of a high school credit can be obtained.

Although the program has the underlying assumption that cooperation and planning between the different institutions is the single most important factor, it would be difficult to implement a similar venture within a bureaucratic, oppressive South African context.

Philip M. Balie
Community Worker
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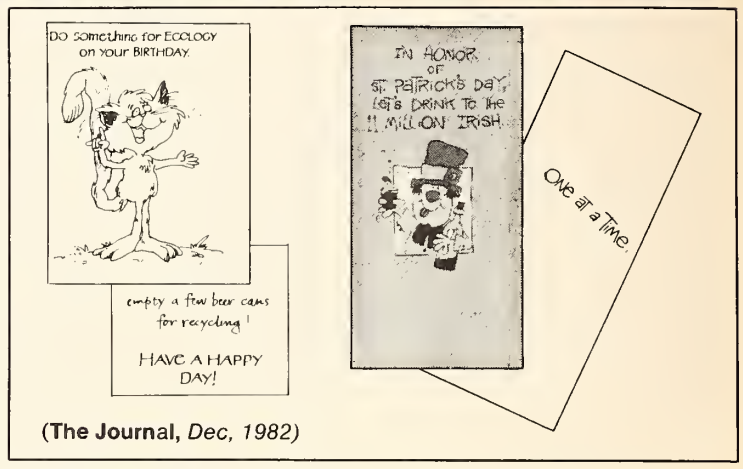
Cape Town, South Africa



(**The Journal**, *Dec, 1982*)

Greeting card messages raise some questions

I read with interest Betty Lou Lee's article on the prevalence of alcohol themes in greeting cards (**The Journal**, Dec, 1982). I have been buying such cards for years now without realizing the "real" message they are sending out — it's okay to get drunk.

The story and especially Mr Finn's remarks have helped clarify this issue. In fact, most purchasers of these cards have probably not, until now, realized there even was an issue.

However, I believe the article falls short in addressing possible solutions to the prevalence of these cards. If they indeed carry a harmful message, what is to be done?

The knee-jerk solution would be simply to move to ban the sale of such cards. However, that could be interpreted quite rightly as censorship or an interference in the free enterprise system. And if these cards were banned, then who is to say that some other groups won't move to ban other types of greeting cards until we're left with only carefully-worded cards that neither amuse nor interest anyone.

Perhaps what is needed is an extension of the research done by Mr Finn. He writes that such cards may reinforce tolerant attitudes toward alcohol abuse without presenting any concrete evidence that such is the case.

Armed with more facts and evidence, alcohol researchers may then be able to approach the greeting card companies with concerns. Only then can possible solutions be considered that will please the researchers and still satisfy the card companies.

In the meantime, it's up to the individual to decide whether he wants to buy such a card the next time a festive occasion rolls around.

S. Norman Jefferson
Des Moines, Iowa

Charter violation?

I wish I could share the confidence of the federal officials who believe that legislation allowing the seizure of assets of drug criminals may be ready by this fall (**The Journal**, Dec, 1982).

However, in light of recent Canadian court decisions on drug laws that involve a reverse onus provision, I find it difficult to believe that any new law with similar provisions will be accepted readily by legislators.

The authors of the report *The Business of Crime* recommend a reverse onus provision as a way of freezing illegal profits until the court has decided the guilt or innocence of the accused. While this is a commendable suggestion, it will likely only lead to more cases in the court on the constitutionality of such a law.

Recently in Ontario, the courts have ruled the reverse onus provision related to trafficking under the Narcotics Control Act violates the right of an accused to be considered innocent until proven guilty. If this ruling is upheld what would stop other lawyers from using this argument for clients accused of making money from selling drugs?

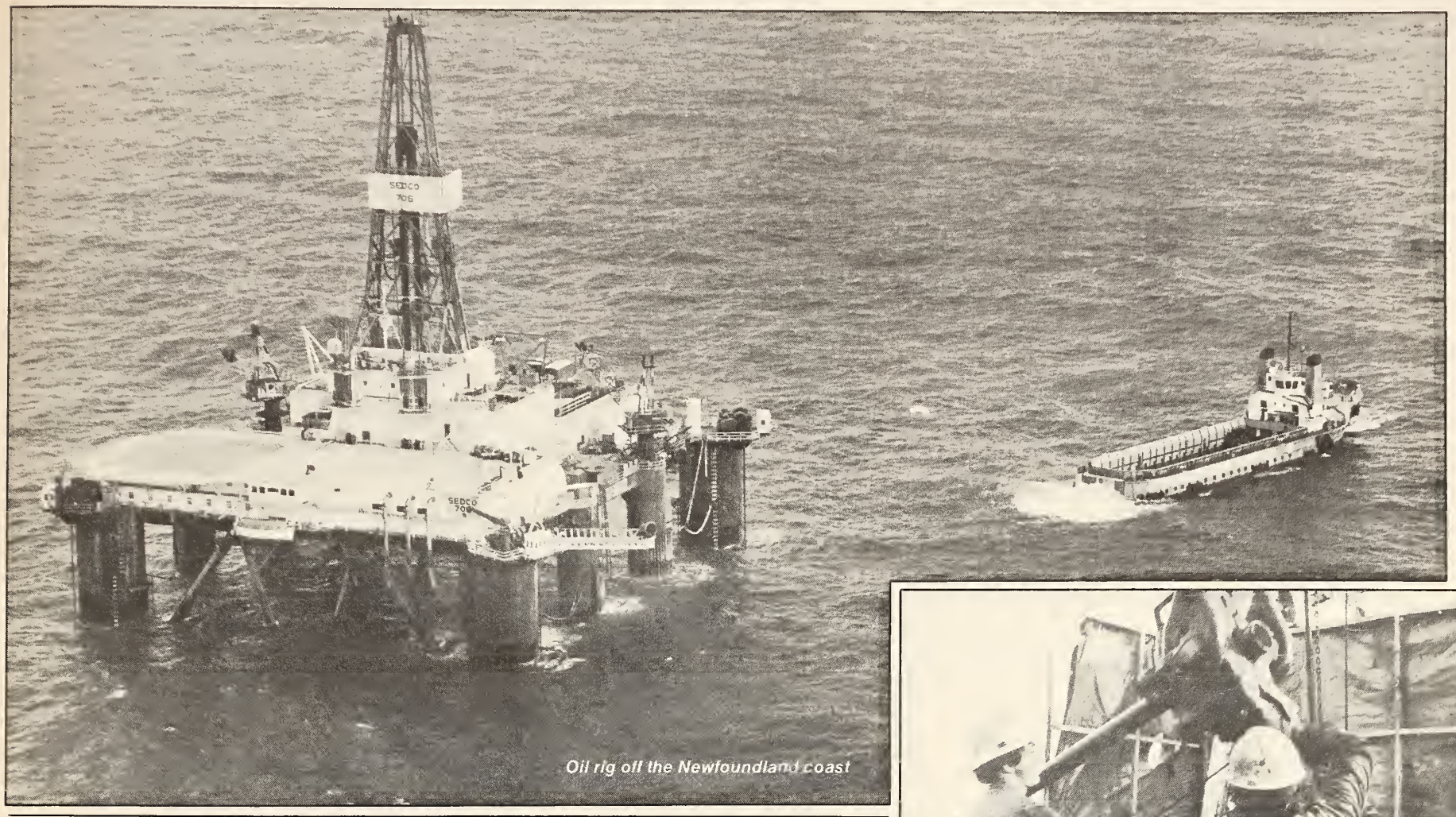
The coordinator of the task force, Rick Mosely, states a similar law in the United States resulted in little public outcry because of rights violations. That may happen in Canada, too. But lack of public outcry won't prevent lawyers from challenging such a law if reverse onus is seen as unconstitutional.

What that may mean is those who profit from drug crimes will continue to do so, this time with the blessing of the court and the Canadian Charter of Rights and Freedoms.

E. Cornish
Kingston, Ont

Letters to the Editor may be sent to: The Journal, **33 Russell St, Toronto, Canada M5S 2S1.**

FEATURE



Oil rig off the Newfoundland coast

Riggers' onshore drinking may spell offshore trouble

Offshore oil rig safety has become the concern of two United States enquiries and a Canadian royal commission following last year's Ocean Ranger disaster off the coast of Newfoundland. The Ranger, one of the world's largest semi-submersible oil rigs, sank during a storm, killing all 84 men on board. The Journal takes a look at another potential rig hazard: the combination of onshore drinking and offshore work. Eileen Morrow reports.

TORONTO — Offshore oil riggers are strictly forbidden to consume alcohol or drugs on the job. But a British study suggests they may drink enough while on shore leave to adversely affect their safety and performance on the rigs.

In a study of 213 oil rig workers in the North Sea off Aberdeen, Scotland, Drs G.J.M. Aiken and C. McCance reported that during the two weeks prior to offshore departure, nearly one-third of the study subjects had consumed levels of alcohol determined unsafe by the British Royal College of Psychiatry. (The upper limit of safe drinking is 56 units per week, the equivalent of four pints of beer per day.)

The study respondents, all male, were divided into three consumption groups: nil, up to 56 units, and more than 56 units. Fifty-nine men had drunk at least the equivalent of four pints of beer per day during the week. Of these, six had consumed in excess of eight pints a day, and a further five in excess of a bottle of spirits a day.

Within the study sample, manual workers (riggers, roustabouts, scaffolders, and deck attendants) were more likely to drink beyond safe levels than executives (platform managers, engineers, technicians, and surveyors). The executive group contained only 17% of heavy drinkers compared to 37% in the manual group.

Overall, the oil men had a far larger proportion of heavy drinkers than other Scottish males, including manual workers and workers in Scotland's distillery industry, which has traditionally had a higher proportion of heavy drinkers than other occupations.

Riggers in the North Sea work two weeks on and two weeks off, on a 12-hour shift system. They're paid high wages just prior to shore leave and traditionally come from backgrounds where heavy drinking is the norm.

The study raises many questions about the effects of intermittent heavy drinking on the health and lifestyles of these workers.

"Work on oil rigs is demanding, and can be dangerous. Those employed could be at risk if their physical or mental capacities were marginally impaired, as they might be for a time following a fortnight's heavy drinking . . . many workers must be arriving offshore in a post-alcoholic state unsuited to the demands and dangers of the job," says the study in the *British Journal of Addiction* (Sept, 1982).

Even if oil rig companies insist workers depart for the rigs sober, people who had been drinking heavily for most of their shore leave would still be impaired by withdrawal effects for several days, the study adds.

The researchers also question the responsibility of oil companies to alert rig workers to the dangers of heavy, episodic drinking.

"It would be simple for the industry to instigate a program to inform its workforce of the amounts of alcohol considered reasonably safe to drink as a normal social practice and prior to embarkation (to the rigs); perhaps it has a duty to do so."

The study urges further investigation into the subculture of offshore workers.

...Nfld officials uneasy about rumors

TORONTO — Alcohol and drug abuse professionals in Newfoundland fear oil rig workers are drinking heavily on shore leave and may suffer after-effects on the job.

Wayne Smith, a consultant with the Newfoundland Alcohol and Drug Dependency Commission, told **The Journal** the island province is in for serious alcohol and drug problems if it doesn't prepare well in advance for the growth oil production will bring.

"We don't have the treatment facilities here to see riggers (and) to do any research on them, but the inklings we're hearing, plus our experience with the North Sea (**see related story**) is that there is an excessive amount of alcohol being used by these individuals," said Mr Smith.

Smith: we don't have the treatment facilities

"We've had two cases or more from our own detox centre of guys who, while they were off the rigs, were brought to the detox. In one case, the guy was physically sobered up, went back to the rig, and then started to experience the real anxiety attached to withdrawal, with all the manifestations of withdrawal.

"If they're working, they run the risk of hurting themselves or someone else they work with," he said.

One of Mr Smith's concerns stems from findings in Scottish and Norwegian studies about the use of chemicals by riggers to regulate sleep and work patterns, despite their prohibition.

"A lot of the hospitals were seeing people with those kind of dependency problems. The riggers were going out there and working for 12 hours while they're on uppers, and then trying to get to sleep as quickly as they can in order to get enough rest to go back on the 12 hours again."

Mr Smith said he's heard stories about alcohol use and its extent among riggers, but is reluctant to talk about specifics without hard data. However, "we're looking at the tip of the iceberg here."

Eve Beck, chairperson of the Newfoundland Alcohol and Drug Dependency Commission, is also reluctant to draw any conclusion.

"We certainly don't have a whole lot of information about that here off (the coast of) Newfoundland," she told **The Journal**.

Ms Beck said the commission has plans to hire a researcher to study alcohol problems resulting from the oil boom. Funding restraints, however, have put the plans on hold.

"One of the things we are going to be doing in the future is start to focus on what's happening offshore. We have lots of data to go on in terms of what's happened elsewhere. But, we don't feel comfortable about saying 'this is the situation in Newfoundland and this is what it's like on the rigs.' We're not at that stage."

John Downton, public affairs assistant for Mobil Oil in Newfoundland, said he's not aware of any major problems caused by episodic drinking or of any accidents that might have resulted from workers coming back to the rigs suffering from hangovers.

Alcohol and drugs are taboo on rigs, Mr Downton added, and riggers get fired immediately if they try to board rigs drunk, or carrying alcohol or drugs.

Mobil has done studies on the impact of oil production on the community but no specific attention was paid to the effects of episodic drinking on safety.

The problems of rig workers are not strictly the responsibility of Mobil because the company contracts the rigs from rig operators (actually, there may be several different companies hiring personnel for work on the rigs). Mobil itself has counselling programs for employees with alcohol problems.

Mr Smith says company officials and others who see the oil boom as a boost for Newfoundland's depressed economy, are naturally reluctant to highlight any of the possible negative effects of rapid growth on the workers or the onshore communities. (**The Journal**, Aug, 1981).

"There's no overt attempt to hide things. It's just to play down and wish that it wouldn't come up. People want jobs at almost any cost."

NEWS

Michigan says no to drunk driving, campaign credited with death-rate drop

LANSING, MI — A media campaign over the Christmas holidays against drinking and driving substantially reduced the number of people killed here in accidents, says the Michigan Substance Abuse Information Clearinghouse.

During the New Year weekend, five people were killed in car accidents in Michigan; four were alcohol-related. This is a sharp drop from a year ago when 17 were killed in alcohol-related accidents.

"I'm profoundly impressed by how effective it (the campaign) seems to have been," says Frank Sheldon, the clearinghouse's project coordinator.

He attributed the drop in deaths directly to the campaign.

The campaign — 'say NO to drunk driving' — began last December and included newspaper ads, posters, bumper stickers, and public service announcements on radio and television. Other groups, such as the local chapter of Mothers Against Drunk Driving (MADD), put out messages, Mr Sheldon says.

A number of licenced establishments allowed the clearinghouse to put posters in the buildings and asked employees to keep an eye on anyone drinking too much.

Mr Sheldon says his group plans to launch two more campaigns this year. The first will make student drivers aware of Michigan's new drinking and driving laws which go into effect April 1.

The new laws will include stiffer penalties and use of preliminary roadside breath tests. It will be automatically illegal to drive with a blood alcohol level of 0.10% regardless of level of physical impairment. Under the old law, it was only "presumed" that 0.10% meant impairment and further evidence had to be presented in court, Mr Sheldon explained.

"All the evidence suggests if you write a tough law (against drunk driving) and you don't keep reminding people about it you lose all the ground you've gained. We must keep alerting people," Mr Sheldon said.

Posters, buttons, brochures, and coasters help Michigan residents learn how to say "No"

Patients setting their own rules in contracts to quit cocaine use

By Betty Lou Lee

OAKLAND, CA — The doctor had been using 45 grams of cocaine a week.

And he knew that a self-incriminating letter he had written to the state medical licensing authorities would be sent if he didn't meet the demands of the people who were holding the letter.

The physician wasn't the victim of an extortionist. He had written the letter voluntarily.

The "demands" were that he stop using cocaine, and they were made by the staff of a specialty clinic in Denver, Co. If his urine samples showed he was still using the drug, they were to mail the letter on to the authorities. It was part of a contract.

"The doctor was hiring me to set controls on his use," Thomas J. Crowley told an international conference on substance abuse here late last year.

Of 33 patients who signed contracts with the clinic, 75% stayed in treatment and were abstinent when the contracts expired in three months. An equal number who refused the contracts were all back on cocaine, or off treatment, within five weeks.

The stakes differed among the patients, depending on what they most feared losing. One gave the clinic deeds to property, with instructions to give them to someone he hated if he didn't stop using cocaine.

Some, already spending up to $100,000 a year on the drug, deposited large amounts of money. Others who feared loss of their jobs or legal involvement wrote letters of confession.

Dr Crowley is professor of psychiatry, University of Colorado, and immediate past president of the Association for Medical Education and Research in Substance Abuse (AMERSA), which sponsored the conference jointly with the World Health Organization. Clinical psychologist Dr Antinette Anker-Helrich was a co-author on the contract study report.

He told the conference that 5% of adults in Colorado used cocaine last year, and, in some ski areas, it was as many as 25%.

Law follows years of lobbying

Israel gets tough on smoking ads

JERUSALEM — Israel will begin imposing tight restrictions on cigarette advertising this spring.

The Knesset (parliament) approved a law recently which will ban the advertisements for tobacco products on (government-controlled) radio and television; movie theatres; public transport, and any outdoor signs. In the newspapers and magazines an advertisement must be subdued, and not use the names or pictures of well-known personalities, anyone below the age of 40 years, anyone in uniform, or anyone wearing sports clothes or a bathing suit.

No advertisement may praise the virtues of smoking.

The law will take effect in April. Its passage follows years of lobbying by interested health groups, who had to battle the media interested in ads.

Advocates of the new law say they hope it will create a social atmosphere against smoking, especially among young people who are just beginning to smoke. The law was first discussed by parliament 10 years ago.

Smoking-related illnesses kill about 3,000 people a year in Israel. While the number of smokers has declined from 42% of the population above age 20 in 1970 to 37% last year, the figure remains as high as 50% for the 20 to 21 age group.

Zorah Gehl, spokesman for the Dubek Tobacco Co, which sells 80% of the cigarettes consumed in Israel, says he doesn't expect the new law to affect sales.

Mr Gehl also said that during Israel's invasion of Lebanon last summer cigarette sales in the heaviest months of fighting — June, July, and August — were 5.73% higher than in the same period the previous year.

The cigarette companies also donated cigarettes to soldiers on duty during the invasion.

Amino acids could assist in healing alcoholic liver

By David Milne

CHICAGO — A treatment for alcoholics with liver disease shows promise in healing the diseased livers and extending the lives of such patients, it was reported here.

Recently approved for use by the United States Food and Drug Administration, the treatment consists of intravenous feedings of amino acids — the building blocks of protein — to patients who may be comatose from liver damage and cannot tolerate normal dietary protein. These findings were reported here at the 68th annual clinical congress of the American College of Surgeons.

One of the developers of the therapy, Dr Josef E. Fischer, chairman of surgery, University of Cincinnati Medical Center, said patients with alcoholic liver disease typically have an abnormal pattern of amino acids in their blood which is thought to interfere with brain function. They cannot be given normal dietary protein, which precludes adequate nutritional support.

The special solution of amino acids given to these patients is called HepatAmine, and is formulated by the American McGaw Co. Research director for the company Dr Norman Yoshimura reported that tests at eight medical centres showed more than 80% of the alcoholic liver patients receiving the treatment for an extended period survived. Fewer than half of comparable patients receiving traditional therapy of protein restraint, carbohydrates, and Neomycin survived.

A comatose patient may receive the special amino acids along with carbohydrates for up to two weeks while his liver rests and repairs itself.

Once past an acute liver coma, patients may be given oral doses of HepatAmine to help their livers continue healing.

'A desperate attempt to rescue an entire generation'

Italy gathers information to battle drug crime

By Thomas Land

ROME — Italy is expected soon to open six large narcotics information gathering centres attached to its embassies in the principal drug-producing countries.

The Ministry of Foreign Affairs here has recently dispatched more than 25 senior diplomats on narcotics intelligence gathering missions.

The most effective weapon in the country's widening war on drug-related crime — described by some specialists as a desperate attempt to rescue an entire generation in peril — is considered to be reliable information.

The promise of Italy's new approach to the global drug trade is illustrated by the recent destruction of perhaps the world's biggest illegal narcotics and arms trafficking organization. It linked dealers in North America, Western Europe, and the Middle East.

But the factors provoking the government to take vigorous action also illustrate the disastrous effectiveness of the crime syndicates. An estimated 100,000 Italians, many of them young people, are drug addicts. Their country has emerged as the principal transit zone for Middle East drugs to the rest of the Western world.

Italy is well-suited for such a role. Its long coastline relatively near the opium-growing regions of the Middle East, its sophisticated business and communications facilities, and its entrenched traditions of organized crime, political terrorism, "black" economy, and weak central government make the country an ideal base for international smugglers.

In addition, the growing economic recession and the resulting unemployment affecting especially a generation of unskilled young people have now created a vulnerable, desperate, local market for drugs. The number of drug-related arrests — an indication of official concern over the problem in an authoritarian society — increased by 30% in 1982. And the mounting intensity of public concern was recently expressed by tens of thousands of usually tolerant residents in Verona in a demonstration demanding decisive official action against the drug trade.

Yet the local market, comprising half of the 10-nation European Community's entire population of addicts, is of relatively minor financial importance to the crime syndicates. The so-called Sicilian Connection is concerned with the illegal processing, transport, and distribution of a big portion of all heroin sold in the Atlantic region of North America and in lucrative markets of North-West Europe.

The Camorra — also known as the Neapolitan Mafia — has emerged as an important middleman facilitating the flow of exports from the cocaine suppliers of Colombia, Bolivia, and Peru to the rich markets of North America and Europe.

The developing links between drug smugglers, arms traffickers, and political terrorists have been long feared by many governments, particularly here in Southern Europe. Judicial allegations made after the recent arrest of a group associated with a Syrian-owned but Italian-based export-import company with branch offices and agents in North America and elsewhere in Europe, appear to confirm these fears.

Judge Carlo Palermo, who is in charge of the investigations, has disclosed that a vast arms-for-drugs traffic had been uncovered involving even such heavy equipment as tanks and helicopters.

The judge said the smugglers had "used their own means of transport," dramatically describing Italy's vulnerability to traffickers exploiting the nation's 5,312 miles of exposed coastline.

The administration is seeking international accord enabling the law enforcement agencies to board and search vessels in the high seas as a preventive measure. More important, Italy seeks improved cooperation with other countries in the exchange of reliable information enabling them to predict the plans and to eliminate the planners of the illegal trade.

Toxic substance linked to deaths of 11 Amsterdam heroin users

AMSTERDAM — Dutch researchers have discovered that an unknown factor was responsible for the deaths of 11 people who inhaled poisoned heroin vapor. Use of the apparently poisoned heroin has also left 37 more people seriously affected.

All the users were chinesing the drug — heating it on tinfoil and inhaling the thick white smoke — and all had obtained it from dealers in the same area of the city, Zeedjik.

When the epidemic was first noticed (**The Journal**, June 1981), heroin users were warned of the danger and encouraged to go to a special crisis centre for screening by a doctor. However, the poison wasn't traced, and users went back to their habit.

A toxic substance must be the cause, authorities believe, but a number have been ruled out — including heavy metals, alcohol, and even vitamin A — because either the symptoms weren't compatible or none were detected among the users. Brain samples of the 11 victims revealed a pronounced type of swelling not known to be a side effect of heroin, says an article in *Lancet* (Dec 4, 1982).

Between early 1981 and Jan, 1982, 47 patients were admitted to hospital with previously unreported symptoms. Some passed through three distinct phases.

The first stage lasted two to four weeks and included such symptoms as motor restlessness, apathy, and disturbance of cerebellar speech. Twenty-one patients remained stable, but the rest passed into the next phase, says the article.

It lasted for the same period and was typified by conditions such as rapid worsening of cerebellar symptoms, and hyperactive and pathological deep-tendon reflexes.

The 11 who went through a third stage experienced stretching spasms, profuse perspiration, and loss of sensory perception. Most of them died because of respiratory problems.

The report also states the course of the disease did not correlate with the duration of heroin addiction or amount used, age, sex, or race.

The researchers from the University of Amsterdam, Free University, and the Dutch ministry of health and environmental protection said the spongey degeneration of the brain's white matter which developed after heroin abuse has not been described before and the disorder has appeared only in the Netherlands.

Alcoholic impotence linked to endocrine abnormalities

By Pat McCarthy

AUCKLAND, NZ — Both endocrine abnormalities and neurological impairment are significant organic causes of impotence in male alcoholics, a study here suggests.

Thirteen abstinent alcoholics aged 31 to 61 years, who complained of erectile impotence, were observed during overnight sleep in the study by five members of the Dean's Research Group at the Wellington Clinical School of Medicine: E.T.H. Tan, R.H. Johnson, D.G. Lambie, M.E. Vijayasenan, and E.A. Whiteside.

Recordings were made of nocturnal erection (which occurs involuntarily during rapid-eye-movement sleep). Electrooculogram, electromyogram, electroencephalogram, and electrocardiogram were also done.

Blood samples were collected next morning to determine sex hormones.

Six patients were found to have diminished or absent nocturnal erections. Plasma concentrations of luteinising hormone and follicle stimulating hormone (FSH) were elevated in all of these except for one who had only raised FSH.

FSH concentrations were significantly higher than in the other seven alcoholics, and the same group also had more evidence of neurological damage.

Plasma prolactin concentrations were abnormally high in eight patients but there was no correlation with abnormal nocturnal erection. Total serum testosterone concentrations were normal in all patients.

The study was reported in the *NZ Medical Journal*, Nov 10, 1982; p 784.

Belize is cracking down on lucrative cannabis market

TORONTO — The small, Central American country of Belize, long a popular transshipment point for drugs en route from South to North America, is now gaining ground as a drug producer.

Illegal shipments of marijuana from Belize last year were worth an estimated $50 million — the country's most lucrative export industry, in the view of some officials.

Although it has only a small narcotics enforcement unit, the government is attempting to control this illegal enterprise, says the Royal Canadian Mounted Police *Monthly Digest of Drug Intelligence Trends*.

In the latest move, the government has brought the sale of aviation fuel under control to try and restrict air trafficking of marijuana. Only licenced dealers will be able to sell the fuel, and it must be deposited directly into the fuel tank of aircraft, the report says.

In the first half of 1982, more than 225,000 kilograms of marijuana were seized, and 286 people arrested for possession or cultivation of the drug.

Authorities also report destroying a 19-hectare field of approximately two million plants near Belize city, and another plantation of approximately 5,000 plants.

Trafficking up, other crime down in Israel

By Macabee Dean

TEL AVIV — With one major exception — trafficking in drugs — there was a decline in the crime rate in Israel in 1982, based on figures for the first 11 months of the year.

Comparisons with the first 11 months of 1981 show files opened against drug traffickers increased by 17.1% to 1,262. However, files against drug users fell by 13.5% to 2,001 cases. The drop is explained not by fewer users but by the fact police concentrated on catching dealers, not users.

Among those categories of crime which dropped were armed robbery, murder, rape, burglary, and other illegal acts against property.

NEWS

Between 1810 and 1830, '90% of United States citizens drank'

Community involvement was key to dealing with old-time drinkers

By David Milne

DALLAS — People in the United States today are more sober than their forefathers were, say the authors of a new book tracing drinking from colonial times to the present. And history provides lessons on how to manage problem drinking, says the book.

"It is very difficult to deal with such a complex issue as alcoholism if we don't know how people have dealt with it in the past," says James Kirby Martin, head of the history department at the University of Houston and coauthor, with colleague Mark Lender, of *Drinking in America.* *

On the plus side, the authors note several ways in which US residents today are better off than drinkers in the past:

- The average person 160 years ago would consider his modern-day counterpart a lightweight drinker. Between 1810 and 1830, when more than 90% of people in the US drank, per capita consumption of alcohol was more than twice what it is today.
- In early times, small communities often used any excuse they could find — like weddings, baptisms, or funerals — to have a get-together and drink.
- In the late 1700s and early 1800s, it was not unusual for young children to drink.
- It was once a habit for workers to drink on the job, often taking a break to have a "4 o'clock dram."
- The authors note, however that there are nearly 10 million problem drinkers in the US today, with excessive drinking costing the economy an estimated $50 billion yearly.

They also point to one reason why drinking is still a major problem even though the average person drinks less. Unlike in the past, drinking today is an individual problem.

"In the colonial period, there was a much keener sense of community among the citizens. If someone was having a problem, the community would deal with that person, says Mr Martin.

Today, he says, Alcoholics Anonymous use many of the methods used in early America to control problem drinking.

* *(Free-Press MacMillan)*

Clients report first drug use before age 17

LANSING, MI — Most people receiving treatment in Michigan's substance abuse network began drinking or using other drugs well before the age of 17 years, says the Michigan Office of Substance Abuse Services (OSAS).

Dick Calkins, OSAS evaluation section chief, says the statistics on first use represent a consistent trend during the past three years.

While some of those treated hadn't taken a drink or used a drug until their 30s, the majority were much younger when they started, he says. For example, 99 clients who entered treatment between April and June, 1982, said their first use of alcohol was before they were five years old.

The drugs most frequently reported as being used before the age of 17 included alcohol, marijuana, PCP (phencyclidine), and inhalants. First use of heroin and cocaine ranged from 18 to 35 years of age.

Mr Calkins says the majority of clients also report using the drug of abuse for at least 10 years before entering treatment. Clients admitted for alcohol problems tended to have used the drug for the longest period of time while those with amphetamine, barbiturate, cocaine, and inhalant problems had been users for the shortest time, he added.

Mr Calkins emphasized the importance of detecting these drug problems at the earliest possible stage.

"It is simply cost effective to get people with problems into treatment sooner, and, additionally, their chances for a successful recovery are improved if this happens. The idea that substance abusers have to hit rock bottom before they should go into treatment is a myth."

RCMP tape looks at drug control methods

OTTAWA — A new videotape production by the Royal Canadian Mounted Police (RCMP), available this month, will give viewers a look at how the force deals with major illicit drugs of abuse in Canada.

The half-hour documentary dramatizes major seizures, concealment methods, and trafficking routes. The proposed title is *Illicit Drug Trafficking in Canada: A Plague Upon Our House.*

Anyone interested in seeing the documentary may contact the RCMP's drug enforcement branch at 1200 Alta Vista Dr, Ottawa, Ont K1A 0R2.

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Margaret Sheppard, at (416) 595-6150.

Death in the Fast Lane

Number: 537.
Subject Heading: Youth and alcohol, impaired driving.
Details: 15 min, 16 mm, color.
Synopsis: A young girl was killed while riding in a car with an impaired teenager who had had numerous other traffic violations, including a manslaughter charge. When tried, he was given only probation. This so aroused people in Maryland that they banded together to form MADD (Mothers Against Drunk Drivers). Other parents discuss their feelings about losing a child or having a child permanently incapacitated because of an accident involving a drunk driver. A plea is made to get involved, to get laws changed so this situation will not continue.
General evaluation: Good (4.3). This film was judged to be a good teaching aid that could lead to attitudes opposed to drug use.
Recommended use: Of benefit to all people 12 years and older.

Pregnancy on the Rocks

Number: 538.
Subject Heading: Fetal alcohol syndrome, women and alcohol.
Details: 58 min, 16 mm, color.
Synopsis: In 1973, Drs Smith and Jones discovered the link between women drinking during pregnancy and facial malformation, retardation, and other physical problems in newborn children. Each of the original mothers studied had been alcoholics. Since then fetal alcohol syndrome (FAS) has been well documented. The next question is: does even a moderate amount of alcohol consumed during pregnancy cause similar problems? Research in France and elsewhere is studying children born with FAS. Several people who have had children with FAS or are FAS children themselves talk about their experience.
General evaluation: Fair to good (3.9). Although this film covered all that is now known about FAS, it was too long and some reviewers objected to the laborious translations of the French research.
Recommended use: Of benefit to health care professionals and adults contemplating having children.

The Troubled Employee

Number: 539.
Subject heading: Employee assistance programs.
Details: 24 min, 16 mm, color.
Synopsis: Two case studies illustrate that an employee who is having problems outside the work place will also have trouble at work. These employees contribute to loss of productivity, accidents, and are often late or absent. This film shows how supervisors should handle such employees in the referral interview and also after they are ready to rejoin the staff.
General Evaluation: Good to very good (4.9). This well-produced, contemporary film was judged a good teaching aid for those involved in employee assistance programs (EAPs).
Recommended use: Of benefit to all those involved in EAPs.

Intervention and Recovery

Number: 540.
Subject heading: Treatment/rehabilitation, professional training.
Details: 28 min, 16 mm, color.
Synopsis: Dr Joseph Pursch illustrates an intervention strategy that can be used to get addicted people into treatment. Case studies are illustrated by the use of puppets to show the pre-confrontation meeting, the meeting, and the role of the members of the intervention team.
General Evaluation: Very poor to poor (1.8). The review group objected to the intervention strategy illustrated and the use of puppets for this subject.
Recommended use: Because of reservations about the type of strategy presented, the group felt this film could be harmful.

Calling the Shots

Number: 541.
Subject heading: Youth and alcohol, alcohol advertising.
Details: 28 min, 16 mm, color.
Synopsis: This film is an illustrated lecture on alcohol advertising. The lecturer illustrates how the advertisers are trying to recruit new drinkers, increase consumption, and get people to choose their particular brand of alcohol. The lecturer contends the ads use sex, prey on feelings of insecurity, wanting to belong, etc to accomplish their goals, and concludes we must be aware of what is happening so we can resist.
General evaluation: Good (4.3). This contemporary film was judged to have a good message although the style of presentation was not particularly appropriate to the medium. General broadcast was recommended.
Recommended use: Of benefit to all audiences 12 years of age and older.

How to Sabotage Your Treatment

Number: 542.
Subject heading: Treatment/rehabilitation.
Details: 30 min, 16 mm, color.
Synopsis: A group of people have gathered at New Years to celebrate success at staying sober. Several recall their experiences in treatment and how the games they played and excuses they used almost "sabotaged" their treatment.
General evaluation: Fair (3.4). Although this film was well-produced the review group found it difficult to decide what its intended message was. The film was also judged long and too positive.
Recommended use: Although the film seems to be intended for therapy groups or health professionals there was no consensus on the use of this film.

We All Have Our Reasons

Number: 543.
Subject heading: Women and alcohol, women and drugs, treatment/rehabilitation.
Details: 30 min, 16 mm, color.
Synopsis: The Alcoholism Center for Women in Los Angeles is attempting to provide an environment for women (including lesbians) where they can discuss and become free of the drugs they have been using. Some of the women living at the centre discuss their feelings before and after treatment and their hopes for the future.
General evaluation: Fair (3.2). As a public relations film for the centre, this film showed what the women were feeling. However, as a general educational tool, the review group thought it was not particularly useful.
Recommended use: Perhaps most useful to health professionals and women needing treatment.

DEPARTMENT

New Books

by RON HALL

The Effects of Maternal Alcohol and Drug Abuse on the Newborn

. . . edited by Barry Stimmel

Drug abuse and alcoholism specialists present findings on the effects of the use of psychotropic substances by women during pregnancy. A paper dealing with the outcome of children born to women dependent upon narcotics concludes that if pregnant drug-dependent women are maintained with low dosages of methadone and are given adequate prenatal care and counselling, complications of pregnancy and childbirth can be minimized. Furthermore, morbidity and mortality during pregnancy, the neonatal period, and in childhood should be substantially reduced. Another paper reviews the evidence for genetic influences in the etiology of alcoholism. The evidence from studies in biologic and adoptive families of alcoholics and from twin studies, is presented. The role of genetic variation in determining individual differences in alcohol sensitivity and tolerance, and in determining the propensity for the development of alcohol induced organ damage is considered. A review of human and animal studies, in a third paper, reveals that alcohol in high doses is a teratogenic. Fetal alcohol syndrome is discussed. Problems in studying the effects of opioids on the human reproductive system and on prenatal and postnatal development are presented in another paper. Ethical constraints usually preclude the administration of any narcotic to humans solely for research purposes. Thus, there are limited human models for study of the effects of opioids on reproductive function and in the perinatal period. The concluding chapter is devoted to a selective guide to reference sources on topics dealing with maternal alcohol and drug abuse.

(Haworth Press, 28 E 22 St, New York, NY 10010, 1982. 167 p. $32. ISBN 0-917724-92-5.)

Today's Disease: Alcohol and Drug Dependence

. . . by G. Douglas Talbott and Margaret Cooney

The main purpose of this volume is to present drug and alcohol addiction as a disease, and provide suggestions on coping with it in a healthy manner. The audience targeted is the lay person. For the alcoholic and drug addict, the principle facts presented indicate this to be not a bad habit, but an incurable, progressive, finally fatal disease. The chemically dependent individual is shown not to have a primary psychiatric disorder. Case reports summarize the authors' experiences in treating alcoholics and drug addicts. Chapters are devoted to the disease, diagnosis, compulsion, relapse, denial, heredity and genetics, the recovery process, Alcoholics Anonymous, and ongoing treatment.

(Charles C. Thomas, 2600 S First St, Springfield, IL 62717, 1982. 174 p. $16.75. ISBN 0-398-04688-3.)

Other Books

Drugs and Drug Abuse: A Reference Text — Cox, Terrence C.; Jacobs, Michael R.; LeBlanc, A. Eugene; and Marshman, Joan A. Addiction Research Foundation, Toronto, 1983. Complete monographs on 64 most-used drugs; shorter notes on 23 others; understanding drug use; cross-indexed by medical/scientific terms, trade names, and street names. Index. 583 p. Addiction Research Foundation, Marketing Services, 33 Russell St, Toronto, Ontario M5S 2S1. $29.50. ISBN 0-88868-073-2.

The Analysis of Cannabinoids in Biological Fluids — Hawks, Richard L. (ed). US Government Printing Office, Washington, 1982. National Institute on Drug Abuse Monograph No 42; radioimmunoassays for cannabinoids; liquid chromatography; assay for cannabinoid metabolites in urine; quantitative analysis; constituents of cannabis and the disposition and metabolism of cannabinoids. 141 p. US Government Printing Office, Washington, DC 20402. $5. S/N 017-024-01151-7.

Social Groupwork and Alcoholism — Altman, Marjorie; and Crocker, Ruth (eds). Haworth Press, New York, 1982. Group curriculum for outpatient alcoholism treatment; stress management program for recovering alcoholics; assertiveness in recovery; treatment model for drinking drivers; spouse participation; family group; women in groups; children from alcoholic families; treatment for the deaf; the elderly. 92 p. Haworth Press, 28 E 22 St, New York, NY 10010. $16. ISBN 0-917724-94-1.

Residential Home Management: A Manual for Managers of Community-Living Facilities — Solomon, Richard; and Solomon, Linda Lerner. Human Sciences Press, New York, 1982. Manual for new and experienced managers: games played; roles and role models; psychiatric drugs; risk factors for suicide. Index. 144 p. Human Sciences Press, 72 Fifth Ave, New York, NY 10011. ISBN 0-89885-037-1.

Substance Abuse Book Review Index 1981 — Bemko, Jane. Addiction Research Foundation, Toronto, 1982. A guide to reviews available in journals; 583 titles of books represented based on scanning 328 journal titles. Indexes. 58 p. Addiction Research Foundation, Marketing Services, 33 Russell St, Toronto, ON M5S 2S1. $6.95. ISBN 0-8868-074-0.

Marijuana as Medicine — Roffman, Roger A. Madrona Publishers, Seattle, 1982. Controlling nausea caused by cancer chemotherapy; reducing glaucoma; managing spasm and spasticity; relieving pain; legal aspects; effects on health and behavior; research studies. Index. 156 p. Madrona Publishers, 2116 Western Ave, Seattle, WA 98121. $5.95. ISBN 0-914842-72-2.

Outcome Evaluation: How to Do It — Spicer, Jerry. Hazelden, Center City, 1980. Types of evaluation; pre-requisites for evaluation; planning and budget; follow-up system; questionnaire design; research design; data analysis; ethical issues. Bibliography, appendix. 70 p. Hazelden, Box 11, Center City, MN 55012. ISBN 0-89486-112-3.

Drug Abuse and the American Adolescent — Lettieri, Dan J.; and Ludford, Jacqueline P. (eds). US Government Printing Office, Washington, 1981. NIDA Research Monograph No 38; epidemiology; personality and sociodemographic factors; transitions of influence among drug-using youth; delinquency; biomedical consequences. 132 p. US Government Printing Office, Washington, DC 20402. $4.50. S/N 017-024-01107-0.

The Pleasure Addicts — Hatterer, Lawrence J.; A. S. Barnes, New York, 1980. Addictive process; food, sex, drugs, alcohol, work, smoking, gambling; therapy; bibliographical resources. 387 p. A. S. Barnes and Company, Cranbury, NY. 08512. ISBN 0-498-02285-4.

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Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Update: Current Issues in Psychiatric Nursing — Mar 14, Apr 18, May 6, June 6, Toronto, Ontario. Information: Evon Essue, Conference secretary, Clarke Institution of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Detox Training Programs (Non-Medical) — Apr 11-15, June 6-10, Toronto, Ontario. Information: Gord Gooding, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

11th Annual Conference on the Family — Apr 21-22, Toronto, Ontario. Information: Anna Cavaliere, Programme Co-ordinator, Centre For Continuing, Education, York University, 4700 Keele St, Downsview, ON M3J 2R6.

25th Annual Scientific Assembly of the College of Family Physicians of Canada — Apr 24-27, Toronto, Ontario. Information: George Ackehurst, Director of Communications, The College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

Canadian Addictions Foundation Annual Meeting — May 2-4, Medicine Hat, Alberta. Information: Jim Edwards, Executive Director, Canadian Addictions Foundation, Pacific Plaza, Box 702, 10909 Jasper Ave, Edmonton, AB, T5J 3M9.

International Conference, Beyond Violence — May 9-11, Montreal, Quebec. Information: GEMS, CP 1016, Snowdon, PQ H3X 3Y1.

International Conference on Prison Abolition — May 26-28, Toronto, Ontario. Information: International Conference on Prison Abolition, c/o QCJJ, 60 Lowther Ave, Toronto, ON M5R 1C7.

Medic Canada '83 . . . Toward the Year 2000 — May 29-31, Edmonton, Alberta. Information: Toby Fay Sykes, Medic Canada '83, 480 Garyray Dr, Toronto, Ontario M9L 1P8.

Canadian Guidance and Counselling Association 9th Biennial Conference — May 31-June 3, Fredericton, New Brunswick. Information: Richard Harvey, Conference Chairman, CGCA '83, PO Box 1983, Station A, Fredericton NB E3B 5G4.

5th World Conference on Smoking and Health — July 10-15, Winnipeg, Manitoba. Information: Kurt Baumgartner, Box 8159, Terminal PO, Ottawa, Ontario K1A 0C1.

24th Annual Institute on Addiction Studies — July 17-22, Hamilton, Ontario. Information: Alcohol and Drug Concerns Inc, 15 Gervais Dr, Ste 603, Don Mills, ON M3C IY8.

Input '83, Alcohol and Drug Addiction Problems in the Workplace — Aug 9-12, Toronto, Ontario. Information: Kathryn Barber, Cochairperson, Input '83, Professional and Management Development, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Royal College of Physicians and Surgeons Annual Meeting — Sept 19-22, Calgary, Alberta. Information: Robert A. Davis, Associate Director, Office of Fellowship Affairs, Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

2nd World Congress on Prison Health Care — Aug 28-31, Ottawa, Ontario. Information: Congress Secretariat, Medical Services Branch, The Correctional Service of Canada, Ottawa, ON K1A 0P9.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: J. Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th Floor, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

New Directions in Patient Communications — Mar 13-15, Williamsburg, Virginia. Information: DIA, PO Box 113, Maple Glen, Pennsylvania 19002.

An Integrated Management System for Administrators in Alcoholism — Mar 14-16, San Francisco, California. Information: Kim Farthing, Program Coordinator, NAATP, 1300 Bristol St N, Newport Beach, CA 92660.

Partnerships in Prevention: The 1983 Carolinas' Primary Prevention Conference — Mar 27-30, Raleigh, North Carolina. Information: Jill Spencer, Charlotte Drug Education Center, 1416 E Morehead St, Charlotte, NC, 28204.

American Orthopsychiatric Association 60th Annual Meeting — Apr 4-8, Boston, Massachusetts. Information: The American Orthopsychiatric Association Inc, 1775 Broadway, New York, NY 10019.

International Parents' Conference on Drugs and Youth — Apr 7-9, Atlanta, Georgia. Information: PRIDE, Robert W. Woodruff BIdg, Volunteer Service Center, Ste 1216, 100 Edgewood Ave, NE, Atlanta, GA 30303.

3rd Annual Conference on Poly-Drug Abuse in the Workplace — Apr 12-13, Akron, Ohio. Information: Keith McClellan, Executive Director, Tri-County EAP, 450 Grant St, Ste 304, Akron, OH 44311.

The National Alcoholism Forum — Marketing the Message — Apr 14-17, Houston, Texas. Information: Daphne Prior, Director of Public Information, National Council on Alcoholism, 733 3rd Ave, New York, NY 10017.

American Medical Society on Alcoholism — Apr 14-20, Houston, Texas. Information: J. Chen See, MD, AMSA, 733 3rd Ave, New York, NY 10017.

Alcohol and Drug Problems Association Eastern Regional Conference — Apr 17-20, Hartford, Connecticut. Information: Eric Scharf, ADPA, 1101 15th St, NW, Washington, DC.

Community Approaches to Adolescent Chemical Abuse — Apr 18-22, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 5544I-6199.

Intervention-Counselling Techniques — Apr 25-27, Indianapolis, Indiana. Information: Kay Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

National Conference on "Working Women and Substance Abuse" — Apr 28-29, Washington, DC. Information: Lee Levin, Administrative Driector, 15 Union Square, New York, NY 10003.

7th World Conference of Therapeutic Communities — May 8-13, Chicago, Illinois. Information: Donna Gleixner, Gateway Houses Foundation, Inc, 624 S Michigan Ave, Chicago, IL, 60605.

TEC (Take Effective Control) — May 11-18, Milwaukee, Wisconsin. Information: Candee Brandis, training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

National Association of Alcoholism Treatment Programs (NAATP) — May 13-16, Kansas City, Kansas. Information: Kim Farthing, NAATP, 1300 Bristol St, North Newport Beach, California 92660.

Scholarly Communication Around the World — The 27th Annual Conference of the Council of Biology Editors, The 3rd International Conference of Scientific Editors and The 5th Annual Meeting of the Society for Scholarly Publishing — May 15-20, Philadelphia, Pennsylvania. Information: 1983 International Conference, Attn: Elizabeth M. Zipf, BioSciences Information Service, 2100 Arch St, Philadelphia, PA 19103.

3rd Annual Conference for Nurse Educators on Current Issue in Alcohol and Drug Abuse Nursing: Research, Education, and Clinical Practice — May 18-20, Washington, DC. Information: Geral Dene M. Burdman (PhD), Alcohol and Drug Abuse Nursing, SC-78, School of Nursing, University of Washington, Seattle, Washington 98195.

5th Annual School on Alcoholism for Physicians and Related Health Professionals — May 19-21, New York, New York. Information: NYU Post-Graduate Medical School, 550 First Ave, New York, NY 10016.

2nd Annual Conference on Alcoholism and the Family — May 25-29, Philadelphia, Pennsylvania. Information: Richard W. Esterly, Chairman, National Conference on Alcoholism and the Family, Box 277, Wernersville, PA 19565.

Pulling Together — The Many Issues of Ethical Principles — June 5-7, Traverse City, Michigan. Information: Sally Myers, MAAA, 29563 Northwestern Hwy, Ste 7, Bldg F, Southfield, MI 48034.

The Mid-South Summer School on Alcohol and Drug Problems — Prevention and Treatment — June 5-10, Fayetteville, Arkansas. Information: Gwen Briscoe, GSSW-UALR, Little Rock, AR 72204.

5th Annual Summer Institute — Alcohol and Relationships: Our Chemical, Ourselves, Our Kids, Our Families, Our Jobs, and Our Intimate Others — June 10-11, Milwaukee, Wisconsin. Information: Candee Brandis, training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Summer School of Alcohol Studies — June 19-July 8, New Brunswick, New Jersey. Information: Gail Gleason Milgram, Education and Training Division, Center of Alcohol Studies, Smithers Hall, Rutgers University, New Brunswick, NJ 08903.

34th Annual Symposium on Alcoholism — Alcoholism and the Family — June 20-July 1, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, Seattle, WA 98122.

Alcoholism in the Workplace — June 21-23, Boston, Massachusetts. Information: Office of Continuing Education Harvard School of Public Health, 677 Huntington Ave, Boston, MA 02115.

Children of Alcohol/Drug-Dependent Parents — July 11-12, Indianapolis, Indiana. Information: Kay Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

World Congress on Mental Health — July 22-28, Washington, DC. Information: World Federation for Mental Health, # 107-2352 Health Sciences Mall, University of British Columbia, Vancouver, British Columbia V6T 1W5.

Sexuality, Intimacy, and Alcohol/Drug Dependence — July 25-26, Indianapolis, Indiana. Information: Kay Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

New Jersey Summer School of Alcohol and Drug Abuse Studies — July 31-Aug 5, New Brunswick, New Jersey. Information: Gail Gleason Milgram, Education and Training Division, Center of Alcohol Studies, Smithers Hall, Rutgers University, New Brunswick, NJ 08903.

National Association of Alcoholism and Drug Abuse Counsellors (NAADAC) — Aug 6-10, Houston, Texas. Information: National Association of Alcoholism and Drug Abuse Counsellors, 951 S George Mason Dr, Arlington, Virginia 22204.

Alcohol and Drug Problems Association of North America 34th Annual Meeting — Aug 28-Sept 1, Washington, DC. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

Drug and Alcohol Issues Symposium — Sept 14-16, Dayton, Ohio. Information: Thomas Prugh, WORAC, 379 W First St, Ste 300, Dayton, OH 45402.

Group Counselling Skills for Alcohol/Drug Clients — Sept 26-28, Indianapolis, Indiana. Information: Kay Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

American Society of Criminology 35th Annual Meeting — Nov 9-12, Denver, Colorado. Information: Joseph E. Scott, Department of Sociology, Ohio State University, Columbus, Ohio 43210.

Alcohol and Drug Problems Association of North America 1983 Western Regional Conference — Nov 13-16, Los Angeles, California. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

Abroad

Pharmacological Treatments for Alcoholism: Looking to the Future — Mar 28-31, London, England. Information: Nina Little, Alcohol Education Centre, The Maudsley Hospital, 99 Denmark Hill, London SE5 8AZ England.

7th World Congress on Acupuncture — May 2-7, Biarritz, France. Information: World Union of Acupuncture Scientists and Societies, 4 Ave Marceau, 75008 Paris, France.

World Symposium on Acupuncture — May 26-29, Bombay, India. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

29th International Institute on the Prevention and Treatment of Alcoholism — June 27-July 2, Zagreb, Yugoslavia. Information: Archer Tongue, International Council on Alcohol and Addictions, Case postale 140, 1001 Lausanne, Switzerland.

9th International Conference of the International Association for Accident and Traffic Medicine — July 10-15, Mexico. Information: Dr R. Andreasson, IAATM, PO Box 10043, 5-100 55 Stockholm 10, Sweden.

8th Institute on Drugs, Crime, and Justice in England and America — July 11-15, London, England. Information: Institute on Drugs, Crime and Justice, School of Justice, The American University, Washington, DC 20016.

7th World Congress of Psychiatry — July 11-16, Vienna, Austria. Information: Congress Team International, PO Box 9, A-1095 Vienna, Austria.

Australian Medical Society on Alcohol and Drug Related Problems 3rd Annual Conference — July 31-Aug 7, Cairns, North Queensland, Australia. Information: Conference Organizers, PO Box 155, Civic Square, ACT, 2608, Australia.

Middle Eastern Summer Institute on Drug Use (MESIDU): Techniques, Strategies, Concepts and Options — Sept, Jerusalem, Israel. Information: Stan Einstein (PhD), Director, MESIDU, 113/41 East Talpiot, Jerusalem, Israel.

International Conference on Alcoholism — Sept 26-30, Reykjavik, Iceland. Information: ICAA, Case postale 140, 1001 Lausanne, Switzerland.

13th International Institute on the Prevention and Treatment of Drug Dependence — Oct 10-14, Oslo, Norway. Information: ICAA, Case postale 140, 1001 Lausanne, Switzerland.

8th World Congress on Acupuncture — Oct 12-16, Seoul, Korea. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

9th International Conference on Alcohol, Drugs and Traffic Safety — Nov 13-18, San Juan, Puerto Rico. Information: T-83 Secretariat, GPO Box 5067, Medical Sciences Campus, San Juan, Puerto Rico 00936.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

2nd International Congress on Drugs and Alcohol — Dec 18-22, Tel Aviv, Israel. Information: Judge Amnon Carmi, Chairman, Organizing Committee, 2nd International Congress on Drugs and Alcohol, PO Box 394, Tel Aviv 61003, Israel.

Alcohol and the brain

By Ernest P. Noble, MD, PhD

The past two decades have witnessed great advances in neurochemistry, neurophysiology, neuropharmacology, and neuroanatomy. The brain, once called a "black box," is slowly, but surely, revealing its manifold wonders and mysteries. We, in the alcoholism field, are the beneficiaries of these advances.

The brain is essentially an electric organ. Billions of cells are arranged in a cytoarchitectural configuration, wherein each cell communicates directly or indirectly with every other cell in the brain. This magnificent, delicate, system imparts to the brain its awesome nature and serves the states of our emotions, learning, cognition, and even our being.

The fundamental unit in the brain is the neuron. Neuron cells communicate with adjacent neurons through the release of a small molecule known as a neurotransmitter. Several neurotransmitters have now been identified. They include: acetylcholine, dopamine, norepinephrine, serotonin, *y*-aminobutyric acid, and others. Electrical impulses in the outer membrane of the neuron, or neuronal membrane, propagate down the body of the neuron into a long stem called the axon, and then continue to the nerve ending where neurotransmitters are released into a small gap called a synapse.

Chemical attachment

Each neuron releases its own specific neurotransmitter which migrates and attaches to its own receptor on the next neuron. This chemical attachment sets off another electrical impulse in this adjacent neuron. When sufficient and specific neuronal networks become activated, certain behavioral and physical states ensue. It is, therefore, not surprising that to understand alcohol's interactions with the brain, researchers have been studying alcohol-induced alterations in membrane as well as neurotransmitter functions.

• • •

Four major alcohol-related phenomena are receiving increased attention by investigators studying alcohol-brain interactions. These include:

- acute effects of alcohol on the central nervous system (CNS);
- development of tolerance;
- development of physical dependence; and,
- toxic manifestations of prolonged alcohol ingestion.

It is important to define at least two of these phenomena.

Tolerance: An adaptive change where an organism, with time, becomes less sensitive to a given dose of alcohol.

Physical dependence: A state in which the organism becomes dependent on alcohol for normal functioning, so that removal of this drug leads to withdrawal syndrome.

Many alcohol researchers have concentrated their attention on two regions of the neuron: The first, the neuronal membrane, in the belief that alcohol-induced changes in this structure may affect impulse conduction, and because changes in this cell component eventually influence the neural transmission process. And second, the synapse, because most mind-altering agents act here to modify the release, uptake, and metabolism of neurotransmitters.

The Alcohol Research Center at the University of California, Los Angeles (UCLA) has been studying modifications in structure of neuronal membranes derived from alcohol-ingesting animals and similar changes in isolated brain cells exposed to alcohol while growing *in vitro*. During acute alcohol exposure, proteins in the neuronal membrane change conformation so that functional groups such as sulfhydryl (SH) and sialic acid (from glycoproteins) become buried. However, during chronic ethanol treatment, these same groups become much more exposed than control tissue.

SH groups have been implicated in impulse conduction, and sialic acid groups are important in the transport of Ca^{++} and other ions necessary in conduction of impulses, as well as the release of neurotransmitters. Changes in the availability of these functional groups may help to explain, in part, the depressant effects of acute alcohol and the enhanced stimulation of the CNS during ethanol withdrawal.

Protein icebergs

Neuronal membranes consist essentially of protein icebergs floating in a sea of lipids or fats. Ions, or small charged particles, are transported actively from the outside to the inside of the neuron through channels between the protein icebergs. The altered electrical charge between the outside and inside of the membrane that ensues during ion transport leads to the initiation of electrical impulse in the neuronal membrane.

During the non-drugged state, some movement or fluidity of proteins and lipids exist in the membranes. However, when alcohol is added, the fluidity of these molecules is increased in the membrane, leading to disruption of the channels through which ions are transported. These changes might account for the depressant effects on the CNS following acute alcohol administration. However, when neurons are exposed for prolonged periods to alcohol, their membranes become less fluidized, or more rigid, because of the continued presence of this drug.

Analysis of membranes exposed for prolonged periods to alcohol revealed changes in lipid composition, with some observations of cholesterol increase and changes in phospholipid composition. These and other observations support the hypothesis that tolerance and physical dependence on central depressant drugs, including alcohol, are associated with a reduction in the intrinsic fluidity of neural membranes.

Dietary manipulation

If this hypothesis holds up, it might be possible one day to decrease development of tolerance and physical dependence upon alcohol, in susceptible individuals, by dietary manipulation. Dietary administration of DL-carnitine, an important carrier for fatty acids into brain cells, during induction of ethanol dependence in mice significantly weakened subsequent withdrawal syndrome.

Altered neurotransmitter functions have also been implicated in alcohol's actions on the brain. Animal studies have shown that during initial phases of alcohol administration — ie, when blood alcohol concentrations rise and stimulating effects of alcohol are observed, brain norepinephrine turnover rate increases. Conversely, when alcohol levels begin to decline, and depressant effects of alcohol ensue, norepinephrine turnover rate decreases.

Similar findings have been observed indirectly in man by administration of *a*-CH3-p-tyrosine, a drug that inhibits synthesis of norepinephrine. Under these conditions, when alcohol was given, volunteers did not experience the "high" or stimulating effects of alcohol. Only the depressant effects of alcohol were experienced.

During the past 10 years, researchers have been investigating potential "sobering" or amethystic agents to try to identify chemicals which, when administered to man, would block acute depressant effects of alcohol on the brain. Available studies show compounds like dihydroxyphenylalanine (a substance converted to norepinephrine in the brain), aminophylline, and ephedrine, enhance the sobering process, without necessarily affecting blood ethanol concentrations.

Recent testing of a combination of natural substances, including vitamins, amino acids, salts, and sugars has shown significant improvement in cognitive and neurological functioning, as well as in emotions, of human subjects intoxicated with alcohol.

The neurotransmitter, serotonin, has been implicated in the development of tolerance to alcohol. In studies where drugs that stimulate or inhibit serotonin synthesis were administered, or where serotonin nerve tracts were cut in the animals' brains, tolerance development was significantly controlled.

Attractive hypotheses

Data concerning the role of neurotransmitters in physical dependence are, at best, equivocal. However, two attractive hypotheses have been proposed to explain physical dependence upon alcohol.

The first states that during continuous ingestion of ethanol and its subsequent utilization, metabolites, specifically aldehydes of neurotransmitters, particularly dopamine, are formed, which then combine with the parent neurotransmitter to produce tetrahydropapaveroline (THP). Since THP is a precursor to the morphine alkaloids in the opium poppy, and small amounts of THP can be converted to the protoberberine alkaloids by rat tissue, it has been suggested that common mechanisms may be responsible for opiate and alcohol addiction.

One study has demonstrated that THP, injected in small doses into the lateral ventricle of the rat brain, significantly alters natural aversion for alcohol in the rat, so the animals drink substantial amounts of ethanol. Unfortunately, others could not replicate this finding.

Another criticism of this hypothesis is that little cross-tolerance and cross-dependence is evident between alcohol and opiates. Moreover, various investigators have been unable to demonstrate the presence of alkaloids in the brain either during or after ethanol administration. Still, this hypothesis is attractive and is currently under active scrutiny.

The second hypothesis, a variant of the first one, follows the recent discovery of new brain peptides, commonly called endorphins or endogenous morphines. (**The Journal**, Jan, 1982) These pain-relieving compounds are small peptides found in the brain. They act on different types of receptors in the CNS, not only to relieve pain but also to bring about a state of euphoria.

It has been proposed that alcoholics have a deficiency of endorphins which they overcome by drinking alcohol. When they cease drinking, endorphins are no longer synthesized, resulting in the withdrawal reaction.

Brain atrophy

Another characteristic of alcohol currently under intense investigation involves toxic effects of alcohol directly on CNS tissue and even more toxic effects of its metabolite, acetaldehyde.

Brain atrophy — loss of tissue — has for many years been considered a major consequence of chronic, heavy alcohol ingestion. A recent summary of several pneumoencephalographic studies of alcoholics showed the proportion of individuals with brain atrophy will range from 50% to 100%, depending on how selective is the alcoholism treatment program.

In the past few years, a more powerful technique than the pneumoencephalogram, called computer-assisted tomography scans (CT scans) has been used to assess brain damage from alcohol abuse. This technique consists of multiple x-ray exposures of the brain from many different angles. Several recent CT scan studies have reported signs of brain atrophy in alcoholics.

Female alcoholics appear to have the same incidence of brain atrophy as males. With abstention, marked improvements have been noted in the CT scans.

Neuropsychological testing of alcoholics has uniformly shown the same pattern of deficits in males and females; namely relatively intact verbal functioning but poorer perceptual-spatial, non-verbal abstracting, and problem-solving abilities. Greatest improvements occur during the first six months of abstention.

What of the effects of alcohol on the brain function of social drinkers? In the first study of its kind, Dr Elizabeth Parker and I administered alcohol usage questionnaires and a neuropsychological test battery to 102 men employed as managers, professors, bank executives, and other professionals. They earned good salaries, 94% were married, most had a good education, and their IQs averaged 120. Their drinking ranged from abstention to heavy drinking, but the heaviest drinkers consumed only one-third the amount of alcohol the average alcoholic would consume.

Results of our findings showed neither the frequency of drinking nor lifetime consumption of alcohol predicted performance. However, larger amounts of alcohol consumed on any one occasion were associated with poorer performance on neuropsychological, adaptive/conceptual tasks. Moreover, an inverse correlation between amounts of alcohol consumed per occasion and performance was significantly higher in social drinkers above age 45 than in social drinkers below that age. Thus, age and the amount of alcohol consumed interact; the older the social drinker and the more alcohol consumed per occasion, the poorer the performance.

• • •

What is the biological basis for the alcohol-induced cognitive deficits or brain damage? Since alcoholics have notoriously poor eating habits, malnutrition has been considered a primary cause. However, recent evidence, derived primarily from animal studies, has caused a modification of this view. When animals were given a more-than-adequate diet, plus ethanol for a prolonged period, they showed, after months of abstention, deficits in learning and other cognitive capacities.

Molecular basis

During the past 12 years, researchers at the UCLA have been seeking to understand the molecular basis that might promote the toxic effects of alcohol on brain function. Efforts have been concentrated on two fundamental and key cellular components: ribonucleic acids and proteins. It is significant that beyond their structure and function in the cell, RNAs and protein have also been implicated in memory, learning, and other cognitive processes.

Researchers have found that rats or mice given a nutritionally adequate diet containing ethanol exhibited a markedly reduced capacity to form new proteins and RNA. Should similar effects of chronic alcohol consumption on these molecules be observed in humans, they may well account for learning deficits, including blackouts and other cognitive dysfunctions found in alcohol abusers. New techniques, such as positron emission tomography, for studying the intact human brain should soon make it possible to shed light on this issue.

The past 15 years have witnessed important fundamental advances in our understanding of alcohol's actions on the brain. We can predict that within the next five to 10 years, we will witness dramatic breakthroughs in our understanding of alcohol-brain interactions, and in the applications of biochemical and pharmacological techniques in diminishing alcohol-induced harm.

Dr Noble is Pike Professor Alcohol Studies, and Director UCLA Alcohol Research Center. Dr Noble, a member of **The Journal's** *Editorial Board, is also former director of the United States National Institute on Alcohol Abuse and Alcoholism.*

Ernest Noble

This paper is adapted from a presentation made by Dr Noble to the 33rd International Congress on Alcoholism and Drug Dependence in Tangier, Morocco in the fall of 1982. References are available upon written request to **The Journal**, *33 Russell St, Toronto, Canada M5S 2S1.*

THE BACK PAGE

Vol. 12 No. 4 2nd Class Mail Reg No 2776 TORONTO, April 1, 1983

The Journal

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Gretzky will speak for Canadian clubs

World group launches global drug offensive

By Mark Kearney

TORONTO — The 1.5 million members of the International Association of Lions Clubs are gearing up for a worldwide fight against drug abuse.

Everett J. Grindstaff, the club's international president, said the Lions are committed to the project for at least the next five years.

The Lions are ideally suited to such a worldwide battle because of the club's international connections, Mr Grindstaff told **The Journal**. He said with some 36,000 clubs in 157 countries and geographical areas, it is the world's largest service club organization.

"During the past couple of years we've been looking for some kind of international program that relates to all the countries we're located in."

The club's international board of directors adopted the drug awareness project last year. In late February of this year, a committee met in Chicago with a team of 11 international experts to help chart the most effective approach to combatting and preventing drug abuse, he says.

"In nearly every area of the world it (drug abuse) was something people related to and were beginning to realize was a problem that could have a devastating effect not only on our youth, who are going to be our leaders tomorrow, but also upon society in general."

Mr Grindstaff said the experts, including H. David Archibald of the Addiction Research Foundation of Ontario and Carlton Turner (PhD), of the White House Drug Abuse Policy Office, will provide continued support and information.

The Lions have the grassroots structure for disseminating information to youths, parents, and other interested groups who want to tackle the problem, he said, and clubs will work closely with government, police, doctors, educators, and media.

Bruce Murray, the Lions International Canadian director from St Mary's Ont, says hockey star Wayne Gretzky will be speaking out against drugs on behalf of the clubs in Canada. Mr Gretzky's involvement is important because he is a person with whom many young people can identify.

Mr Murray will also be touring the country to help publicize the Lions' project and ensure the commitment both nationally and locally to drug awareness.

"I'm convinced that the competition between various countries and geographical areas will be healthy for the program," he says.

"We believe prevention is certainly the cure," Mr Grindstaff

(See — Grassroots — p 2)

Luke Golobitsh

Teen drug abuse: the focus of increasing interest and concern from the grassroots to the ivory towers (Stories pages 1, 9, 15, and The Back Page).

Teen anti-smoking plan paying off

By Harvey McConnell

WASHINGTON — Programs that have helped reduce incidence and prevalence of cigarette smoking in young adolescents have been adopted for drug abuse prevention among 50,000 Los Angeles students over the next four years.

C. Anderson Johnson (PhD), of the health behavior research institute, University of Southern California, said results of the institute's anti-smoking programs among 10th grade students suggest cigarette smoking is a strong predictor of alcohol and marijuana use.

The anti-smoking programs resulted in reductions in alcohol and marijuana use.

Dr Johnson said: "The cigarette smoker is more than twice as likely as the non-smoker to start using marijuana and alcohol. And the more one smokes, the more likely one is to start using marijuana and alcohol."

The findings, combined with the knowledge that social and psychological precursors of cigarette smoking are similar for alcohol and marijuana use — such as peer and parental use and risk-taking behavior — led to the design of the new drug abuse prevention research project.

Dr Johnson outlined the method at a seminar organized by the United States Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) which is funding the program.

He said institute researchers know the anti-smoking programs work: incidence and prevalence of cigarette smoking were reduced by 50% to 75% in three groups aged 11 to 13 years. The reductions held true 2½ years later in follow-up studies.

Dr Johnson said a key element in the program is emphasis on factors important to teenagers; social consequences such as the yellowed teeth and fetid breath of smokers, for example, are much more important than long-term health consequences.

A second essential is to have programs conducted by peer leaders of the same age. "We find these leaders by asking a class to write down the name of three or four people in the class for whom they have

(See — Peer — p 2)

He paid Sherpas in cigarettes

Sir Edmund Hillary confesses

By Pat McCarthy

AUCKLAND, NZ — The new patron of an anti-smoking group here, Sir Edmund Hillary, the New Zealand mountaineer who conquered Mt Everest in 1953, has confessed he was once one of the biggest cigarette suppliers in Nepal.

Sir Edmund said he paid his Sherpa guides and porters in cigarettes instead of cash in his early days with Himalayan expeditions — and became the unwitting star of a tobacco advertisement.

"Many years ago, it was an accepted policy on the expeditions to supply porters with free cigarettes, although I was a non-smoker," he said. "Finance was difficult, and I accepted an offer of some thousands of cigarettes from a New Zealand tobacco company."

Friends later sent him clippings showing him apparently endorsing that particular brand with the words: "Naturally, I choose only the best."

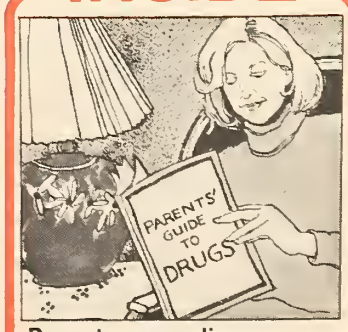
Hillary: unwitting ad star

After that, Sir Edmund said, the cigarettes stayed at home and members of his expeditions were paid in cash.

"If they wish to smoke, that must be their personal responsibility, but, in practice, few expedition members smoke and few of the more vigorous Sherpas smoke at all. We in New Zealand could do well to follow their example."

Sir Edmund has become patron of ASH (Action on Smoking and Health), a group sponsored by New Zealand's National Heart Foundation, Cancer Society, and Asthma Society.

INSIDE



NEWS

Briefly. . .

Anti-pot spots

WASHINGTON — Three, 30-second television spots and three, 30-second radio spots about marijuana use will be issued later this year by the United States National Institute on Drug Abuse. The public service messages include brief discussions by young teenagers on how smoking marijuana has affected their lives. State and local drug abuse agencies and interested private organizations will be encouraged to take part in promoting the campaign.

Wine at the doorstep

LONDON — Milkmen here may soon be more aptly called 'winemen' if the trend to home deliveries of wine continues to boom. In an effort to fight the economic slump, milkmen from Unigate Dairies are now leaving wine at the doorstep along with the traditional milk and eggs, says an article from the *Alcohol Research Information Service*. A company spokesman says that while sales are "fantastic," this doesn't mean customers are drinking more. "We offer only a very high quality of wine," he says, "not just the kind you buy to get blasted."

Orphan drugs funded

WASHINGTON — The United States pharmaceutical industry is being offered up to $75 million a year in tax breaks for developing "orphan drugs" for rare diseases. US President Ronald Reagan said he had some reservations about the bill creating the tax incentive payout, but signed it anyway. It ended a fight which has been waged for years by those who need compounds to treat diseases which affect a relatively small number of people but are devastating to those who suffer from the conditions. Often, it is not commercially tempting for companies to develop drugs for such illnesses.

Food tops pub sales

LONDON — Food has taken over from beer as the money maker in many British pubs, according to the publisher of an annual guide to pubs. Egon Ronay said one reason for an "explosive" growth in food trade in pubs is that it is cheaper to eat in pubs than in restaurants, and tough economic times mean people are pinching more pennies. Another factor may be taxes on beer and spirits, which have risen sharply in recent years and are now reflected in reduced sales.

'Chaw' no better

DALLAS — Young athletes trying to sidestep the hazards of smoking by chewing or sucking tobacco are on the wrong track, says a Texas study. William G. Squires, an assistant professor of biology at Texas Lutheran College, says oral smokeless tobacco decreases cardiac output during exercise. The tobacco also increases blood pressure and reduces maximum oxygen consumption, he says in an article in *Medical World News*. Cardiac output, stroke volume, blood pressure, and oxygen consumption of six young men were measured during work-outs on a treadmill before and after they held a chaw of tobacco between cheek and gums for five minutes.

Automatic pardon proposal may add to public confusion

By Mark Kearney

TORONTO — Granting automatic pardons for marijuana possession won't address the "real issue" of whether it should be a criminal offence, say two authors of a paper on cannabis control policy options.

Robert Solomon, of the University of Western Ontario's faculty of law, says a government proposal for automatic pardons won't remove the stigma of having a criminal record.

"It isn't enough," he told **The Journal**, if the proposed legislation is merely going to allow a person to say he's never been convicted.

He was commenting on Canadian Solicitor-General Robert Kaplan's announcement in March that he is studying a proposal that would allow people found guilty of minor offences, such as possession of marijuana, to receive pardons automatically if they've had no other convictions.

Mr Kaplan is hoping the proposal, which may be introduced in parliament by June, would allow pardoned people to say they'd never been convicted and remove the stigma they bear.

Such a pardon may clear a person in the federal government's eyes, says Mr Solomon, a consultant on law to **The Journal**.

However, it won't have any impact on local press coverage of the conviction, credit agencies who may clip the stories for future reference, local police and court records, and future employers who might question the person about the arrest and trial, he adds.

Pat Erickson, (PhD), a criminologist and drug control researcher at the Addiction Research Foundation, says Mr Kaplan's proposal is laudable but wonders if the door will still remain open for future policy changes.

Dr Erickson and Mr Solomon are co-authors of a forthcoming cannabis control policy paper which says the existing law has cost a lot of money, used a sizeable proportion of the criminal justice system's resources, "and burdened tens of thousands of young Canadians with a permanent criminal record for conduct which is commonplace among their peers."

Dr Erickson adds that the government's proposal seems to give the illusion that something is being done about cannabis "without really doing anything."

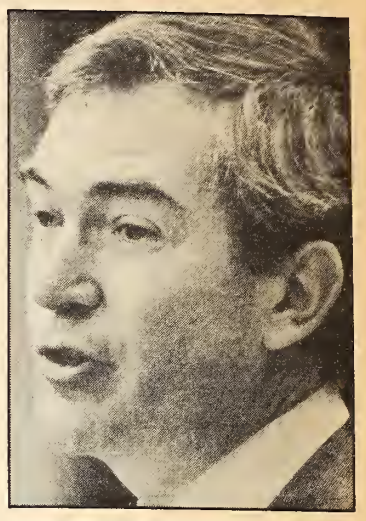
If the automatic pardons are perceived as a step toward decriminalization of marijuana, it is only a "very, very marginal" one, she says.

An aide to Mr Kaplan told **The Journal** the proposal isn't trying to address the question of decriminalization; it's attempting to improve the "forgiveness feature" of pardons and allow more people to receive them.

If approved, the proposal would eliminate bureaucratic red tape and the need for lengthy police investigations that exist now before a pardon is approved, the aide says.

A pardon under the Criminal Records Act is a means of formally recognizing that an individual has been rehabilitated. Under existing law, those pardoned may not say they were not convicted, but may say they were pardoned of an offence.

The aide says it will be up to parliament to decide on the wording of any new legislation, but it's likely an automatic pardon wouldn't occur until at least three years after conviction.



Kaplan: remove stigma

Mr Solomon says that unless the new legislation is clear, the public may regard automatic pardons as a panacea.

"My cup doesn't runneth over with confidence that it (the proposal) won't further confuse the public," he said. The public may see this as a shift in government attitudes toward marijuana when it is really just one small way of dealing with one aspect of the issue, Mr Solomon added.

About 1.7 million Canadians have a criminal record, many because of a conviction for possession of marijuana.

Last year 10,115 people applied for pardons and 6,332 were granted compared to 380 applications and nine approvals in 1970. The increase is believed to stem largely from applications by people convicted of marijuana possession.

Grassroots committed

(from page 1)

said. "There's no hard or soft drugs. We're after any type of abuse of drugs. Or alcohol."

He said some clubs are already training members to speak about drug abuse to concerned groups and developing audio-visual material for distribution.

Leos, the youth branch of the Lions, may also help establish youth programs and leisure activities that will provide healthy options to the drug lifestyle, Mr Grindstaff added.

Although the board of directors will provide information and direction, local clubs will tailor the approach to their own needs based on community or country problems, he said.

Early response to the idea has been overwhelming, he explained. Even in areas such as Thailand and South America where drugs are a large part of the economy, club members are enthusiastic.

"This has not kept them from being involved even though they realize it is a means of income for a certain number of people (in their country)."

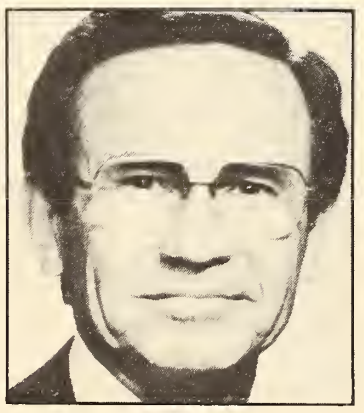
Mr Grindstaff has no estimate of how much money is committed to the project; it will come from fundraising activities by individual clubs. However, many of the 325 people in the international headquarters in Oak Brook, Illinois are monitoring the project's progress.

Why should the Lions succeed where others have not?

"Manpower. The people who are involved, well, they're involved people. They're involved in other facets of life. They have a special desire to try to make their communities and their nations a better place to live," he said.

"A lot has to be individual initiative, but we have faith in the individual that they're sold (on the project), they're going to read up on it and get to work."

Murray: competition healthy



Grindstaff: no soft drugs

Peer leaders 'buying into' teen anti-smoking programs

(from page 1)

most respect," Dr Johnson said.

Many of the peer leaders are "modest deviants" who are risk takers but not in real trouble. Most agree to take part in the program, and they are given special training.

Dr Johnson said in comparison studies the institute team found the effects last longer if peer leaders "buy into" the program than if the program is conducted by a teacher. One reason is the peer leaders are always with the class.

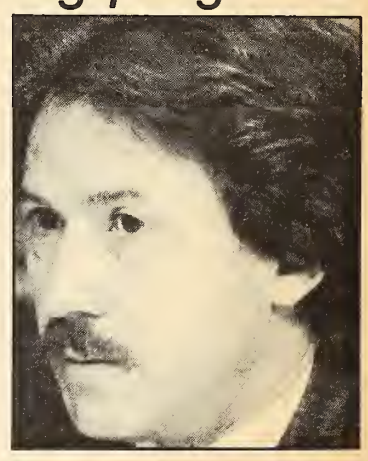
Students are taught how to reduce the pressures on them to smoke and ways they can say no to smoking. Attempts are made to change the perception that smoking is a normal thing to do, and students are asked to make public statements that they will not smoke.

Dr Johnson said the programs adopted for drug abuse prevention are called Project SMART (self-management and resistance training) and are aimed at preventing alcohol, marijuana, and other drug use.

The programs started a year ago and have reached 6,000 students so far; they will reach some 50,000 students over the next four years in the Los Angeles Unified School District.

One arm of the program will closely follow the anti-smoking program format with the focus on social aspects of drug use rather than health consequences, and provision of skills in saying no to drugs.

Peer leaders recruited to run the programs help give students new expectations so that *not* using drugs is considered normal and respected by their peers. And public commitments to avoid drinking and the use of others drugs are solicited.



Johnson: saying no to smoking

Dr Johnson said the second approach is a self-management program designed to enhance students' self-esteem, and teach them decision-making skills and ways to control moods.

Dr Johnson said each program is being tested in two ways: a single-year program for each of the grade 6, 7, 8, and 9 levels, and a multi-year program which will cover the same students from grade 6 through grade 9.

He and his colleagues are optimistic the approaches which have worked so well in preventing cigarette smoking will be as successful in preventing alcohol, marijuana, and other drug use among adolescents.

Correction

A printer's error was responsible for a missing line in the article "Misguided fears of narcotic abuse foil good pain cure: AMA president," (**page 1, March**). The line identified Dr Raymond Houde, head of the analgesic study section, Memorial Sloan Kettering Cancer Centre, New York.

Study finds controlled drinking more appropriate goal

Abstinence 'unacceptable' to some drinkers

By Karin Maltby

TORONTO — Controlled drinking is a more appropriate objective than abstinence for socially-stable, early-stage problem drinkers, says a study which traced 70 outpatients of the Addiction Research Foundation's (ARF) Clinical Institute here.

A "negative result" was found in that there was no difference between the abstinence and controlled-drinking groups in the amount of alcohol consumed at six-month follow-up, says the study by Martha Sanchez-Craig and Helen Annis, PhDs.

However, 86% of subjects assigned to controlled drinking reacted favorably to a goal of moderation, while a large proportion of those assigned to abstinence (66%) rejected this goal from the outset.

Compliance to the assigned drinking goal during the course of treatment was higher in the controlled drinking group: while 80% of the subjects in this group drank moderately, only 20% in the abstinence group abstained, says the study.

Also, during the six-month, post-treatment discharge, a large proportion in the abstinence group (67%) developed moderate drinking practices on their own. Only two subjects maintained abstinence.

Dr Sanchez-Craig: "When you ask clients to assess acceptability of the goal, most of the people assigned to controlled drinking were satisfied, happy with that option. A large proportion of those assigned to abstinence said they were not happy. They could consider abstinence for a brief period of time, but they couldn't make it their life goal."

The study goes on to say the extent of non-compliance to abstinence "strongly suggests that this goal is unacceptable to the population under study. It may be that the requirement of abstinence is especially aversive to early-stage problem drinkers since, typically, they do not perceive themselves as 'sick' or 'diseased'."

Dr Sanchez-Craig told **The Journal** some of the subjects were recruited through newspaper advertisements which outlined an

Sanchez-Craig

Annis

ARF preventive program for early-stage problem drinkers, and others through the intake of the Clinical Institute.

"They are a socially-stable, working population, and, at the time of the study, they were making above the Canadian average income. Most of them had some university education. They are highly-functioning people who are drinking on the very heavy side — but still without apparent medical symptoms and with low dependence on alcohol," she said.

The subjects had no evidence of liver disease, neuro-psychological impairment, or other health problems that might contraindicate moderate use of alcohol. In addition, they believed moderate drinking was possible; were non-participants in Alcoholics Anonymous; had had no extended periods of abstinence in the past two years; had about five years of problem drinking; and successfully maintained a job, home, or stable relationship.

Dr Sanchez-Craig said that at no time were the subjects aware two treatment goals were available.

"We advertised the preventive program, but there was no mention of the treatment goal. And since it was outpatient, there was no way in which people could exchange notes about what was happening," she said.

Although no difference was found between groups in amount of reported alcohol consumption at outcome, differences were observed regarding the relationship between intake and follow-up measures, says the study.

In the abstinence group, weekly consumption at intake "was positively correlated with follow-up weekly consumption, a typical finding of outcome studies." However, in the controlled drinking group, the two sets of measures were not significantly correlated.

This unexpected finding, the study suggests, may mean some heavy drinkers are "capable of reducing their alcohol intake quite dramatically provided abstinence is not demanded of them. Certainly, the formulation of a hypothesis of this sort requires replication of this result."

Dr Sanchez-Craig: "One of the most interesting findings of the study is that in the abstinence condition you have a positive relationship between drinking at intake and drinking at six months. That means, if you were a heavy drinker you will continue to be, within the sample, a heavy drinker. In the controlled drinking condition, you don't have such relationships."

A similar treatment package was given to both groups, in individual, weekly sessions.

Clients were given a description of the treatment objectives and the specification of abstinence or controlled drinking as a long-term goal. Clients in the controlled drinking group were asked to abstain for the first three weeks of treatment.

The validity of the clients' self-reports was corroborated by neuropsychological and biochemical liver tests which are sensitive to the effects of alcohol, said Dr Sanchez-Craig.

The subjects were taught coping strategies and problem-solving techniques by Dr Sanchez-Craig and Ken Macdonald of the Mississauga ARF Centre.

In addition, the controlled drinking group was trained to moderate their drinking. This involved rules and guidelines for moderate drinking with respect to frequency, maximum number of drinks per day, type of beverage, and appropriate and inappropriate drinking situations.

Treatment was terminated when the clients achieved proficiency in problem-solving and self-monitoring procedures, and had confidence in their ability to use the treatment procedures on themselves, says the study.

They were asked to contact their therapists in times of crisis, to continue self-monitoring their drinking, and to bring their records to follow-up interviews.

The two treatment conditions did not differ significantly in number of counselling sessions, number of weeks in treatment, or the percentage of clients completing treatment.

However, significantly more subjects in the abstinence group received aftercare counselling sessions than in the controlled drinking group.

Of 70 subjects, 35 were placed in each treatment condition. Sixty-seven people from the entire group completed the treatment program, but only 59 were interviewed at six-month follow-up. Five in the abstinence condition and six in the controlled drinking condition were unavailable: four could not be located, four refused to collaborate, and three continued to postpone appointments.

Although the investigators had thought socially stable drinkers would be easier to follow than drinkers with a more chronic problem, such was not the case.

"In the experience of the investigators, who have also worked with chronic, unemployed alcoholics, early-stage drinkers who change address are more difficult to locate since they may not be readily traced through official records."

That subjects showed improvement in cognitive functioning after three weeks of abstinence or consumption of small amounts of alcohol, "suggests the importance of adhering to very conservative drinking goals in the initial stages of therapy," says the study.

Drs Sanchez-Craig and Annis continued to follow the subjects at 12 months, 18 months, and 24 months. Dr Sanchez-Craig says the six-month outcome results had "held up" for both groups at those stages. A final report on the 24-month follow-up is being prepared.

New research council will target priorities

TORONTO — The new Health Research and Development Council of Ontario could help make the work of the Addiction Research Foundation (ARF) better known throughout the province, says ARF President Joan Marshman, (PhD).

She says research scientists sometimes only know what is happening in their own discipline. Once the council is in place coordinating all health research in Ontario, scientists may be able to get a better perspective on how the work at ARF, for example, might be integrated with other health projects, Dr Marshman told **The Journal**.

Marshman: better perspective

It's too early to determine how ARF's budget and the nature of its research will be affected by this new council, but the foundation has long been committed to improving treatment services and improving prevention and health promotion, she says.

Health Minister Larry Grossman announced the formation of the council in early March saying it would "ensure that appropriate levels of funding over specific periods of time are directed toward problems of priority concern to our health services system and to the needs of scientific enquiry."

Council members are expected to be appointed by early summer.

Of thwarted bestsellers — or tales that don't transfix

By Wayne Howell

The eclectic nature of the New Books section of **The Journal** might give the reader the impression that **The Journal** reviews all books that are submitted for perusal. That is not quite correct. There are books which, for one reason or another, do not get reviewed. Traditionally, these also-rans are thrown out in the springtime. For what it's worth, here are capsule reviews of a few of last year's rejects:

Perspectives in Pac-Man Symbolism — Julia Throcton. Lea, Witter, and Boggs, Los Angeles, 1981. Ms Throcton sees the video arcade game, Pac Man, as a complicated allegory about cocaine use. It is no accident, she says, that the Pac-Man character appears only as a head with a large mouth. Pac-Man's physiognomy obviously represents an individual who is orally fixated. This oral fixation has led Pac-Man into seeking immediate pleasure from stimulant drugs, and the fact he is constantly pursued by ghosts indicates he is suffering from the paranoia that accompanies heavy cocaine use. Poor Pac-Man scurries about his maze (the rat-race of modern life) with his personal demons in hot pursuit. His only respite comes when he makes a connection in one of the corners with an "energizer dot." This gives him a rush of sudden power that allows him to turn on his personal demons and pursue them. But only for a time. Soon the "energizer effect" of the drug wears off, symbolized by the ghosts changing back to their original colors, and once again Pac-Man must run from his personal demons. The video tragedy continues until Pac-Man is literally destroyed by the monsters pursuing him.

According to Ms Throcton, Pac-Man is a powerful educational tool against drug abuse and she recommends its installation in all National Football League locker rooms.

Dealer Databasing — Osborne Adams. Aspen Business School Publications, Denver, 1982. This is a critical look at software available to that growing number of drug dealers who own personal computers. It also includes an introduction to BASIC programming for those dealers who deal in off-beat hallucinogens and find commercial softwear does not fulfill their immediate needs. Of the many electronic spread-sheets on the market, Mr Adams finds the popular "VisiCalc" program ideal for projections of future profits. Should I cut it to 10% or 15% and what will this mean to street sales? In seconds, "VisiCalc" provides an answer. Mr Adams also recommends "dBase II" as an off-the-shelf program for customer lists, especially for those with CP/M operating systems which utilize number codes to prevent access by unauthorized individuals, namely the cops.

The Stockholm Connection — David P. Warner. Transworld Publishing, London, 1983. This is a fast-paced tale in the Len Deighton, Frederick Forsythe tradition based on a true incident. It concerns the two volume report on alcohol use and misuse prepared for Margaret Thatcher's government by a mysterious "think tank." the report that Mrs Thatcher informed parliament was "not for the public eye." Despite the British Official Secrets Act, the report was spirited out of Britain and published in a Swedish University. I don't want to give away the plot, other than to say that it involves a homosexual spy, a Cambridge don, a beautiful typist with access to cabinet documents, a Swedish transvestite, and a talking horse.

Modifying Your Turntable to Receive Drug Propaganda — H.J. Wilson. Popular Mechanics Press, Philadelphia, 1982. This is a must book for people who like to hear pro-drug messages encoded in rock music. Up until now, a person could only hear such messages if he owned a tape recorder capable of playing in reverse and the cassette version of a rock concert. Mr Wilson gives the reader step-by-step instructions for modifying direct-drive and belt-driven turntables so records can also be played backwards, allowing a much wider audience access to the encoded messages that are destroying and enslaving young people. Mr Wilson is candid about the fact that his suggested tinkering with the turntable drive mechanism will result in the voiding of the manufacturers' warranty, but he feels the exercise is worth it. One backwards-listening of the hit single PacMan, for instance, with its clearly audible message ("sno . . . or . . t . . . koh . . . uk") endlessly repeated, is enough to convince any individual that a conspiracy is abroad in the land.

NEWS

RESEARCH UPDATE

Quaalude accidents up

Quaaludes and other methaqualone drugs are now claiming more victims through auto accidents and other violent deaths than drug overdoses. A study of the 246 methaqualone-related deaths between 1971 and 1981 in the Miami, Florida area shows 77% of the deaths occurred since 1977, and 72% involved fatal trauma such as auto accidents (one third of all the deaths), other accidents, and suicides. Charles Wetli, University of Miami, said the pattern has changed since the early 1970s when most of the deaths were from overdoses. "Currently the effect of methaqualone on behavioral modification seems to have a much more substantial impact on society, both economically and medically, than the potential for overdose." The study noted the effect of methaqualone alone, or in combination with other substances, is reminiscent of acute alcohol intoxication. Dr Wetli called for legislation to restrict the drug and detect it in apparently intoxicated drivers.
Journal of the American Medical Association, Feb 4, 1983, v 249:621-626

Nighttime cigarette ban

When nine, male, habitual smokers with duodenal ulcer took a drug intended to impair gastric secretion at night and then smoked, acid secretion was far higher than on a night when they didn't smoke. Researchers E. J. S. Boyd, J. A. Wilson, and K. G. Wormsley, University of Dundee, say since patients with duodenal ulcer secrete abnormally large amounts of gastric juice at night, being able to inhibit this is an important effect of many antisecretory drugs. "While patients who smoke habitually often do not or cannot heed advice to stop smoking completely, a recommendation to avoid smoking after taking the nighttime antisecretory tablet should be acceptable, and . . . may prove to be clinically relevant and useful," the study concluded.
The Lancet, Jan 15, 1983, v 8316:95-97

Methadone treatment success unpredictable

Two California researchers have found it is not possible to predict which heroin addicts will do best in a methadone program. Barbara Judson and Avram Goldstein followed up 171 people five years after they had received at least six months treatment in a California methadone program. They looked at 19 possible predictive variables such as the addict's drug use, employment, living situation, marital status, criminal activity, education, age, sex, and race. While pre-treatment histories of heavy alcohol use, criminal activity, and minority ethnicity pointed to a poor outcome after treatment, no significant correlation was found between any pre-treatment variables and a good outcome. Thus, they said, *a priori* judgements should not be made as to who to admit for methadone maintenance treatment since there are so few predictors of outcome.
Drug and Alcohol Dependence, Dec 1982, v 10:383-391

Alcohol disrupts heart rhythm

Alcohol in modest doses can produce heart rhythm disturbances in heavy drinkers with heart disease, a study from Ohio indicates. Fourteen patients with a history of chronic alcohol consumption and symptoms of palpitations or lightheadedness were studied at the Ohio State University Hospital. After 90 mL each of whiskey, 10 of the 14 patients developed sustained or nonsustained atrial or ventricular tachyrhythmias. Drs Arnold Greenspon and Stephen Schaal said their findings give credence to reports of sudden death after alcohol consumption.
Annals of Internal Medicine, Feb 1983, v 98:135-139

Smokers' weight loss tied to lung function

A Belgian study suggests weight loss in smokers may be the consequence of impaired lung function. Four researchers from the cardiopulmonary laboratory, Cliniques Universitaires, Saint-Luc, Brussels, studied 272 steelworkers aged 45 to 55 years and found smokers weighed significantly less than non-smokers. Findings indicate the lower weight and body mass index of smokers was attributable to a subset of subjects with obstructed airflow. "We may hypothesize," the researchers said, "that susceptible (to lung disease) smokers differ from resistant ones by their cellular response to cigarette smoke." They said the findings may partly explain conflicting results relating overweight and general mortality in epidemiological studies and that loss of excess weight in a middle-aged smoker could point to deteriorating lung function and susceptibility to chronic obstructive lung disease.
British Medical Journal, Jan 22, 1983, v 286:249-251

Coffee and cancer link

A large United States study gives further support to the theory linking coffee consumption and cancer. A population-based, case-control study was conducted of all residents of Connecticut aged 21 to 84 years with bladder tumors diagnosed between January 1978 and January 1979. After controlling for age and smoking, Loraine Marrett, Stephen Walker, and J. Wister Meigs found people who drank more than seven cups of coffee a week had a significantly greater risk of getting bladder cancer. For males the risk increased with increased coffee consumption. The researchers admit to problems with this sort of retrospective study (imprecise recall, changing consumption, data collection methods etc.) but say "despite the lack of understanding of the precise role of coffee, our results suggest that about one quarter of bladder tumors in Connecticut might be attributable to drinking more than one cup of coffee per day."
American Journal of Epidemiology, Feb 1983, v 117:113-127

Pat Rich

Early-stage binges by mom linked to fetal CNS defects

By Incor Jowat

CARMEL, CA — Some defects in the central nervous system of unborn infants are caused by binge drinking by the mother early in the pregnancy, suggests a researcher at Dartmouth Medical School, New Hampshire.

John Graham, assistant professor of maternal and child health at Dartmouth, said case reports, epidemiological investigations, and experimental studies which his group have conducted, all point to this conclusion.

"In the human, the third week of gestation is the sensitive period for the induction of neural tube defects," Dr Graham said. (The neural tube forms the central nervous system in the embryo.)

Dr Graham said a number of recent retrospective case-control studies have linked specific illnesses during this period to neural tube defects. Also, in many anecdotal case reports of birth defects, he said binge drinking figured prominently in the histories of the mothers.

A study of the epidemiology of neural tube defects shows an unusual seasonal incidence, he said.

Canadian data show "significantly higher mortality rates from anencephaly (a severe birth defect) for winter births than for summer births."

Other studies from England and Wales show spring conceptions run a significantly higher risk for neural tube defects, Dr Graham said.

"It is possible alcohol consumption by susceptible individuals, possibly in response to springtime depression, might explain some of the observed seasonality for neural tube defects."

Dr Graham and other Dartmouth researchers further showed the relationship between binge drinking and neural tube defects with tests conducted on golden hamsters.

They found it was possible to induce a significant frequency of neural tube defects in hamsters whose mothers had received a high dose of alcohol during the critical period.

Dr Graham said the dosage was "equivalent to staying drunk for a fairly significant period of time in a human.

"These data suggest that exposure to binges of alcohol during early gestation can result in serious malformations in experimental animals.

"Anecdotal and epidemiological evidence in humans suggest that we are not resistant to such anomalies."

Dr Graham presented the work at the annual meeting of the western section of the American Federation for Clinical Research.

Educators should recognize the handicap

FAS children need special care

By Ken Zeilig

LOS ANGELES — Primary school educators must learn to recognize children who are handicapped by fetal alcohol syndrome (FAS) rather than simply labelling them as "slow learners" or "behavior problems," says Ann P. Streissguth, FAS researcher.

At the same time, she says, a question that needs investigating is how many children there are with normal IQs but with learning disabilities caused by alcohol-related effects.

"Once the child (with FAS) is born, he needs whatever kinds of service any child with problems would have — whether or not he's got alcohol-related problems.

"Any child who is a slow learner should be given every opportunity to develop to his full potential and have the proper kind of schooling, tutoring, and education. They really aren't different, from that standpoint, in their needs, but they tend to put stresses on homes and classes because of their hyperactivity," Dr Streissguth, professor, department of psychiatry and behavioral science, University of Washington School of Medicine, told **The Journal**.

"I see a lot of children with FAS," she continued. "I get a lot of calls from school teachers wanting to know about these children and how to handle them."

(FAS is a constellation of physical, mental, and growth abnormalities seen in varying degrees in the offspring of some chronic alcoholic mothers.)

Some children with FAS may get through primary school without much trouble, Dr Streissguth told a symposium here on the psychobiology of alcoholism. But "a lot of them pass through the school system and then drop out early with bad grades."

Dr Streissguth said FAS children look small and young for their age, creating a tendency to brush aside their learning difficulties. "They treat them the age they appear to be rather than the age they really are."

This factor may work well for FAS children, she said, because they are treated at their own level in contrast to overgrown, retarded children.

"In general, these children need the same kind of handling as any child does, followed by an accurate assessment of the type of learning disabilities they have. What is called for is individualized programming. In a sense their needs aren't different from any other disabled children," Dr Streissguth said.

In her opinion FAS children present more problems to their primary care givers. They tend to be hyperactive, impulsive, and flighty. They can be poor feeders: "They look really skinny so that makes people feel they ought to eat more in the belief that will help them get healthier. But then they are often disinterested in food, especially at the early ages. These children have higher than normal frequency-of-eating problems, sucking problems, and a general failure to thrive."

However, Dr Streissguth noted several case studies where children in adoptive homes — and their caregivers — were "happy."

"They don't see their slow behavior as a problem at all. And that's fine as long as they are getting along well and doing what they can in school," she said.

These lowered expectations, in a way, can tend to be better for the FAS children, she said.

Canada ponders fate of Zomax

By Mark Kearney

TORONTO — The prescription painkiller Zomax (zomepirac sodium) could be off the market for weeks pending a decision by Health and Welfare Canada on whether to revise the drug's monograph.

There was no decision at press time. Jean Sattar, speaking for Health and Welfare Canada, says data from the United States are being collected before any decision is made.

However, the ministry supports the decision of McNeil Laboratories (Canada) Ltd to withdraw Zomax from the market, she says.

Zomax was taken off the market in March following reports that one person in Canada and five in the United States died after taking the drug.

McNeil Laboratories in Stouffville, Ont voluntarily withdrew the drug throughout Canada and asked people taking it to return unused portions to their pharmacists. McNeil is a subsidiary of Johnson and Johnson which also withdrew Zomax from the US market.

Dr Walter Forgiel, director of scientific affairs for McNeil, says he has few details on the deaths but says the Canadian death was from gastric bleeding and two in the US were people who were acetylsalicylic acid (ASA)-sensitive.

"There were contraindictions (on Zomax's monograph) that patients who were ASA-sensitive shouldn't take it," Dr Forgiel told **The Journal**.

He says the monograph was clear about who should and who should not take Zomax. There were no problems in premarketing clinical trials, Dr Fogiel says.

Dr Forgiel says the company will study the deaths and re-examine the monograph in consultation with the health protection branch of Health and Welfare Canada.

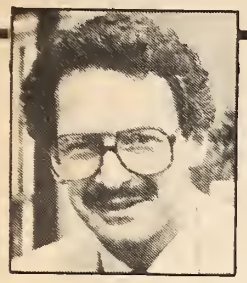
Health and Welfare Canada has received more than 100 "adverse effects" reports from users of Zomax, says Ms Sattar, but none of them were fatal, allergic reactions.

The monograph for Zomax outlines the possible dangers to those who are hypersensitive to ASA, Ms Sattar says.

"The warnings were clear that it shouldn't be prescribed to that type of person."

An estimated 750,000 patients in Canada and 15 million in the US have used the drug for pain in the two years it has been available.

COMMENT



GILBERT

'NNS may be a better aid to giving up cigarettes'

Tobacco research at the ARU

By Richard Gilbert

Last month I wrote about the Addiction Research Unit (ARU) in London, England, and outlined the ARU's research on drugs other than tobacco. I noted that approximately half of the effort of the unit concerns tobacco. This month I shall describe this work, with a focus on the use of nicotine as an aid to quitting smoking.

The head of the ARU's tobacco research section is Michael Russell, perhaps the best known of contemporary researchers on smoking. Russell, a physician by training, has published important articles on almost every aspect of the tobacco habit, ranging from nicotine metabolism to econometrics. I have met him often, but not while I was preparing this column. For the information here I am indebted mostly to his associate, Martin Jarvis, who made it clear that Russell is the inspiration and guiding light for ARU's tobacco research.

Russell's working hypothesis is that most tobacco use is a consequence of a pharmacological dependence on nicotine. This has led him to explore nicotine-based ways of both reducing the harm caused by smoking and eliminating the tobacco habit.

Adding nicotine

The ARU was in the headlines a few years ago when Russell advocated the production of low-tar cigarettes with added nicotine. The amounts of tar and nicotine delivered by a cigarette are highly correlated. Consequently, a low-tar cigarette can be very unsatisfying for a smoker because of the low nicotine yield. Smokers will use more of the low-tar cigarettes, or they will smoke in ways that increase both tar and nicotine yields. In either case the risk to health is increased. A low-tar cigarette with added nicotine would provide ordinary satisfaction of the nicotine habit but reduced risk from the carcinogens and other chemicals in tobacco smoke, including carbon monoxide — yields of which are also highly correlated with tar yields.

Adding nicotine to low-tar cigarettes might make the cigarettes safer, but it could also reinforce the smoking habit rather than cure it. For this reason, moves to create safer cigarettes are regarded with much suspicion by many researchers and others interested in reducing the harm caused by smoking. Indeed, I have heard of funding agencies refusing in principle to support work leading to safer cigarettes. Proponents of safer cigarettes, including Michael Russell, argue that, whatever we do, millions of people will continue to smoke, and that reducing the risk to their health is a worthwhile venture.

Recently, however, Russell and his coworkers have concentrated on nicotine-based aids to giving up smoking. Some of this work is described in an article by Jarvis *et al* with the title "Randomised controlled trial of nicotine chewing-gum" that appeared in the *British Medical Journal* last August. Would-be quitters were given either gum containing two mg of nicotine per piece or placebo gum containing one mg of unbuffered nicotine per piece. The placebo gum provided the bitter taste of nicotine with much reduced pharmacological activity. The active gum was in the form of Nicorette, a commercial preparation available in Canada on prescription since 1979 (**The Journal**, July, 1980).

The controlled trial showed clearly that nicotine chewing gum can be an aid to quitting the tobacco habit. One year after the start of the study, 27 of the 58 users of the nicotine gum were not smoking, whereas only 12 of the 58 users of the placebo gum had quit. Most users of the active gum had stopped using it within six months: only four of the 58 used it longer, thereby demonstrating some kind of dependence on the gum. Both gums caused minor side effects including vomiting, dizziness, sore throat or mouth, headache, faintness, hiccups, mouth ulcers, and indigestion. Users of the active gum reported a lower incidence of withdrawal symptoms than the placebo group. They were less irritable, less sleepy, and less hungry.

Currently at the ARU, nicotine chewing gum is being used as a tool to determine the extent to which withdrawal symptoms are the result of the absence of nicotine as opposed to the loss of the familiar behavior of reaching for, lighting, and smoking a cigarette. An ongoing study is comparing heart rate, skin temperature, various biochemical measures, self-reports of moods, etc, in applicants to the Maudsley Hospital's smoking clinic.

Gum effective

The study is presented as a preliminary to treatment. Subjects are assigned to five groups and examined four times during a 10-day period. One group is asked to quit completely. Another group is asked to switch to a lighter cigarette. The third and fourth groups are given gum; one has active gum and the other the placebo gum. The fifth group is a control. The degree of compliance is determined from tests of expired carbon monoxide and plasma nicotine levels.

The initial results are that measures from subjects using the active gum and the low-nicotine cigarettes are similar and lie mostly between those of the control group and those of the other two groups. For example, both the active gum and the low-nicotine cigarettes reduce withdrawal symptoms but heart rate remains chronically elevated as in regular smoking.

The active gum and the low-nicotine cigarettes differ in that the gum reduces craving less. Because the two do not differ in their physical effects, the different impact on craving could be taken as evidence for behavioral dependence on nicotine.

Martin Jarvis cautioned that this does not necessarily follow: the local pattern of delivery of nicotine differs between the gum and the low-nicotine cigarettes. Although the cigarettes and the gum yield similar amounts of nicotine, the nicotine from the cigarettes is concentrated into 'bursts' that occur with each puff, whereas the gum provides a relatively continuous flow of nicotine into the bloodstream. These bursts could be the basis of craving. A definitive test of the extent of behavioral dependence could be achieved only with the use of cigarettes that contain no nicotine at all but taste and feel the same as regular cigarettes.

Jarvis takes the evidence so far to suggest that nicotine chewing gum is a useful but inefficient aid to quitting smoking. He, Russell, C. Feyerabend (a biochemist at New Cross Hospital who is a frequent collaborator with the ARU), and Ove Ferno (vice-president of A. B. Leo, the Swedish company that manufactures Nicorette) are developing and testing a nasal nicotine solution (NNS). NNS is in effect a kind of liquid snuff although the researchers don't like to use this term.

NNS is literally squeezed into the nostril, (as Jarvis is doing in the photograph). Preliminary tests suggest it may be more acceptable to quitting smokers than nicotine gum because it gives them a nicotine "buzz" within a few minutes of use. Examination of plasma has shown that a two mg dose of nicotine by the nasal route produces a peak of 14.1 nanograms/millilitre after 7½ minutes compared with a peak of 8.5 ng/ml after 30 minutes of chewing gum containing the same amount of nicotine. When the same three subjects smoked a cigarette yielding close to two mg nicotine, peak plasma levels averaged 25.7 ng/ml with the peaks occuring within five to 7½ minutes.

Solution better

Thus the pattern of absorption of nicotine from NNS seems similar to that from cigarettes, and NNS may, as a result, be a better aid to giving up cigarettes. NNS has fewer side effects than either nicotine chewing gum or tobacco snuff, use of which carries a slight risk of lung cancer. Administration of NNS requires some skill (as does use of most forms of nicotine). If the user sniffs too hard it can run into the throat and cause mild distress. If the sniff is too gentle the solution runs out of the nose, in spite of its viscous consistency.

The chief disadvantage of using NNS as an aid to quitting smoking would seem to be that dependence on it may develop rapidly and be as difficult to eliminate as the smoking habit. On the face of it, dependence on NNS would constitute less of a hazard to health than dependence on cigarettes, but potential users of NNS should be aware of the risk. Using NNS in public might be considered socially unacceptable, which could be an aid to giving up nicotine altogether or a cause for relapse to cigarette use.

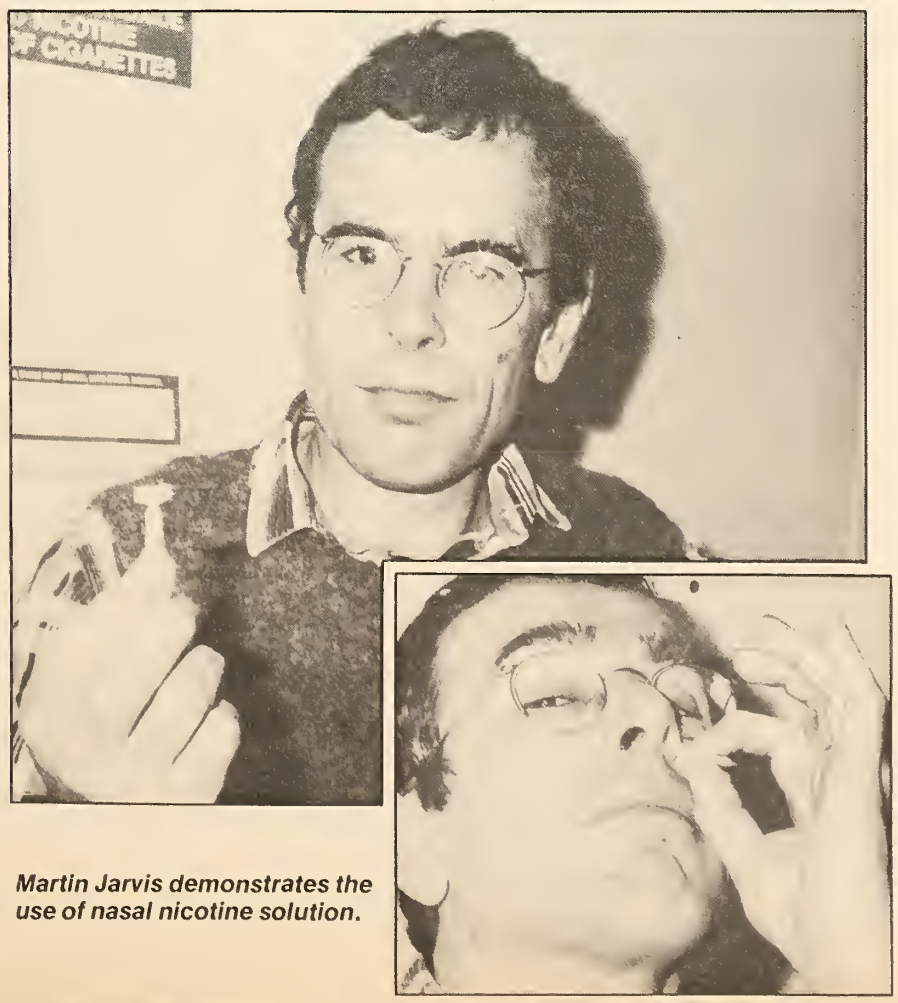
Other ongoing work by Jarvis and Russell concerns the characterization of smokers and non-smokers — a difficult job because of the unreliability of self-reports. The smoking behavior of outpatients of cardiology and peripheral vascular clinics is carefully correlated with the saliva or plasma levels of cotinine (a nicotine metabolite) and levels of carbon monoxide in expired air. Cotinine levels provide the most accurate marker, but carbon monoxide is much easier and cheaper to measure. The carbon monoxide test is valid 95% of the time with nine parts per million as the criterion for smoking.

The same study is showing a very clean linear relationship between cotinine levels in non-smokers and their exposure to second-hand tobacco smoke. The range is from one ng/ml to four ng/ml, which compares with plasma levels in the order of 300 ng/ml cotinine in smokers.

Jarvis and Russell are about to begin two further studies. One is to do with how intravenously-administered nicotine modifies cigarette consumption — with the obvious aim of achieving better understanding of the role of nicotine in smoking. Earlier work in many labs has shown a surprisingly small effect of intravenous nicotine — an uncomfortable result if you believe nicotine drives the cigarette habit.

The second study will look at the effect on smoking of predosing smokers with enough carbon monoxide to achieve smoking levels. Although it is unlikely that smokers smoke *for* carbon monoxide, they may quit a bout of smoking because of distress caused by high carbon monoxide levels, and carbon monoxide may thereby have a role in the regulation of smoking.

Other work on smoking at the ARU mostly concerns quitting the tobacco habit. Steve Sutton and Rob Hallett are using anti-smoking videotapes in industrial settings to examine their utility in getting workers to quit.



Martin Jarvis demonstrates the use of nasal nicotine solution.

2,000 smokers

Bob Merryman has just reached the end of a clinical trial of Nicorette. Two thousand smokers were treated in one of three ways. Smokers in one group were given the gum together with advice on quitting. Those in another group were given advice only. The third group was a control. At the end of the year, 11% of the first group had quit but only 5% of each of the other two groups, again supporting the claim that nicotine chewing gum can be a useful aid to quitting the cigarette habit.

The ARU is closely associated with the Smokers' Clinic at the Maudsley Hospital. The current thrust there is to study and develop the effectiveness of intervention by general practitioners in reducing the amount of smoking in the community, using the clinic as a resource both for the GPs and their patients.

One other smoking study is under way at the ARU. Jill Devitt maintains a panel of 100 continuing smokers who are examined in various ways three times a year as they progress in their natural smoking careers through various types of cigarettes and survive various disturbances to their smoking habit. What is striking so far is the stability of the measures, particularly the carbon monoxide levels.

In spite of massive cutbacks in funding for research of all kinds in Britain, the ARU seems deservedly secure for the next five years. In my view, the ARU provides remarkable value for the small amount of money invested in it, and should act as a model in this respect for many other research centres.

NEWS

UK experts advise banning GPs from treating addicts

By Jane Corrigan

LONDON — British experts in drug addiction have told the department of health to ban general practitioners — both private and National Health Service (NHS) — from treating addicts, in an effort to stem an epidemic of drug abuse throughout the United Kingdom.

The advice follows publication of a report by the UK's Advisory Council on the Misuse of Drugs (**The Journal**, Jan) which claimed that the "unplanned" involvement of general practitioners in addiction treatment and the lack of an authoritative statement of good practice had caused many difficulties.

"Liberal" prescribing had flooded the black market with opiates, particularly Diconal (dipipanone hydrochloride and cyclizine) and barbiturates and had drawn addicts away from the clinics to the GPs who became well known as "prescribers."

The payment of fees, invariably charged by GPs, the Council said, "inhibited the establishment of an effective therapeutic relationship between doctor and patient." And in cases where the patient had no regular income, the practice might push the addict into selling his prescription.

Concern about the absence of comprehensive hospital services to treat addicts led the Advisory Council not to advise that GPs be ousted totally from the care of addicts. Instead it recommended stricter safeguards be implemented.

But doctors from addiction units, meeting with representatives of the British Medical Association (BMA) and the department of health, were unanimous in their conviction that whatever other treatment was available, GPs should not be allowed to prescribe for addicts.

Behind the decision was the striking off in December last year of a West London GP who admitted to having 250 private patients who paid him a £10 consulting fee each time he wrote a prescription for Diconal.

At the hearing of the General Medical Council (GMC), the professional conduct committee was told there was no real problem in West London until 1980 when the West London doctor had opened his "clinic." Since then there had been a "notable increase" in the use of Diconal.

Speaking for the GMC, Philip Otton, QC, said the doctor, who was a member of the District Health Authority and in group practice with three partners, had abused his position as a GP and provided private patients with prescriptions other than for bona fide treatment and quite clearly for monetary gain.

The Advisory Council concluded that but for the absence of an authoritative statement of good practice, more GPs would have been disciplined by the GMC.

After the meeting, Frank Wells of the BMA said the overwhelming consensus was that despite the existence of many highly ethical GPs working in the field, the penalty of allowing the loophole to continue was too high.

"The problem we face is one of enormous over-prescribing," Dr Wells said. "That is why we are convinced that the GP's role must only be to refer the patient to the clinic."

PGI_2 production low in smokers

Team spots possible key to smoking-related heart disease

By Incor Jowat

CARMEL, CA — A potentially important link between smoking and cardiovascular disease has been reported by a group from the medical department of the University of Southern California Medical Center in Los Angeles.

Jerrold Nadler, reports that nicotine cigarettes reduce prostacyclin (PGI_2) production.

Smoking is a major risk factor in the development of accelerated cardiovascular disease, and, while many mechanisms have been proposed, the precise relationship between smoking and vascular disorders has not been shown, Dr Nadler told the annual meeting here of the Western Society for Clinical Investigation.

The study said the normal, healthy relationship between blood vessels and platelets may be critically dependent on the production of two prostaglandins, thromboxane and PGI_2. PGI_2 is formed from substances in the walls of arteries and veins and is a potent dilator of blood vessels and inhibitor of the clumping together of platelets.

Earlier studies have shown that tobacco and nicotine can influence the critical balance between blood vessels and platelets. Dr Nadler's study examined the effect of smoking on PGI_2 production in humans.

A group of 10 healthy smokers and 10 non-smokers smoked four nicotine-free cigarettes and four cigarettes containing 1 mg of nicotine each over a four-hour period on separate days.

An attempt was made to ensure that the smokers and non-smokers inhaled the cigarette smoke in a similar fashion, and urine samples were collected from all subjects every hour during the study period.

Dr Nadler said the study found the nicotine-free cigarettes had no significant effect on the release of PGI_2 in either the smoking or non-smoking group.

The non-smoking group showed an increase in pulse rate and other side effects while smoking the high-nicotine cigarettes, but there was no change in the level of PGI_2 production.

However, in the smoking group, PGI_2 production dropped when the high nicotine cigarettes were smoked.

Dr Nadler said the results were reproduced with the same smoking subjects on two separate days and have been demonstrated with other subjects.

He said the study shows that "nicotine-containing tobacco may chronically reduce vascular $PG1_2$ production which may represent a key mechanism of smoking-related cardiovascular disease."

Further studies are underway with cigarettes containing varying levels of nicotine, he said.

Smokers should be isolated says British Safety Council

By Alan Massam

LONDON — The British Safety Council has come up with an idea that will chill the hearts of many smokers but cause rejoicing elsewhere.

Smokers, says the council, should be required to smoke in special booths installed in homes and public places. James Tye, director of the council said: "These 'Addict Booths' should be placed in a prominent position, not out of sight.

"This will substantially improve the environment for non-smokers and also substantially reduce the risk of fire," he said. "I would particularly like to see smoking prohibited on trains, and 'addict areas' set aside on every platform. Anyone who could not contemplate the idea of travelling without recourse to a quick drag would then have to get off the train and head for the nearest booth."

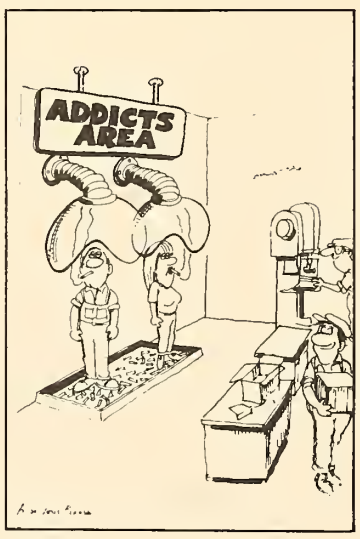
Mr Tye said he is seriously concerned about cigarettes as a cause of fire.

Figures from the Home Office show that from 1970 to 1980 there were 7,400 non-fatal casualties and 1,988 deaths from fires started by smokers' materials in Britain.

The threat of fire in public places always increases where smoking is permitted, and two serious conflagrations within the past two years were directly caused by cigarettes. The first was the Stardust Disco fire in Dublin in Feb, 1981, when 48 people died. The second case was a London Underground (subway) fire in Apr, 1981, caused by a burning cigarette blown into a tunnel.

Mr Tye also believes smokers' booths should be built in the homes of smokers as one in four home fatalities is caused by smoking-related fires. He says the booths should be centrally located so anyone wanting a cigarette could make a "burning assignation" with the booth.

He said: "I am well aware this idea will prove unpopular with those who resent anything which appears to curtail freedom of the individual. But we are in the field of accident prevention, which means recognizing a risk and dealing with it before an accident has occurred."



Smoker's booths could be the answer for safety

Emergency staff could screen alcohol victims

By Tony Garnier

WELLINGTON, NZ — Hospital patients with alcohol problems may be more receptive to seeking treatment if they are confronted while the damage caused by their drinking is present.

This "confrontation" would be facilitated if alcoholism assessment and treatment resources were available in accident and emergency departments, especially during evenings and nights. The aim would be to treat the patients with significant alcohol problems or refer them to other agencies.

At the very least, these hospital departments need to consider and develop such policies, modify attitudes to alcohol abusers, and improve the usually inadequate intervention efforts.

These were conclusions of a study to estimate the prevalence of alcohol use and abuse in patients aged 16 years and more attending the accident and emergency department at Wellington Public Hospital in late Jan, 1982.

A week-long, round-the-clock survey used an objective measurement of blood alcohol level (BAL), an alcohol identification questionnaire, and an alcohol consumption history. The findings were presented to the 10th biennial summer school conducted by the New Zealand National Society on Alcoholism and Drug Dependence (NSAD) in Wellington recently.

Drs Marie McCarthy, Steven Donn, and Geoffrey Robinson, said one important finding was that 88% of head injury cases had a positive BAL.

"Breath alcohol analysis (in accident and emergency departments) could rapidly assist in defining the contribution of alcohol to depressed levels of consciousness," they suggested.

Of 421 patients interviewed, 12 refused to take the breath test. Eight of these 12 were clinically intoxicated.

Sixty-five showed a positive blood alcohol level and in 47 of these, the BAL was greater than 0.08%, the legal limit for driving in New Zealand. In 56 of these 65 patients, alcohol was judged to play a definite part in contributing to their accident or illness, and may have indirectly contributed in a further seven cases.

The data identified 21 dependent alcoholics, 28 hazardous drinkers, and 22 problem drinkers. Nine patients with a positive BAL had no significant drinking problems, although it was considered alcohol may have contributed to the attendance of seven of these cases.

A positive BAL was found in 20% of those visiting the accident and emergency departments between 5 pm and midnight, and 32% between midnight and 8 am.

The investigators said the results suggested emergency service patients are a suitable population to screen for early-phase, problem- and hazardous-drinking.

They suggested a breath alcohol analysis be done on all emergency patients smelling of alcoholic beverage.

US court says ingredients list must be on label

WASHINGTON — A list of ingredients in spirits, wine, and beer for sale in the United States should be available within the next year.

This is the ruling of US District Court Judge John Pratt, who upset a decision by the administration of President Ronald Reagan to rescind the requirement issued by the administration of former president Jimmy Carter.

The ingredient-labelling requirement was decided after a 10-year study by the US Bureau of Alcohol, Tobacco and Firearms. A suit was filed by the Center for Science in the Public Interest to restore the regulations.

Judge Pratt said the Reagan administration had acted in an "arbitrary and capricious manner." He threw out the order, and gave the bureau a month to announce a date, within the year, in which the original rule will take effect.

US resists vote on block of 26 drugs

UN forum turns down benzodiazepine control

By Behrouz Shahandeh

VIENNA — Efforts to bring the benzodiazepines under international control received a major setback when the United Nations Commission on Narcotic Drugs failed to reach the necessary two-thirds majority here in February.

The World Health Organization (WHO) had recommended that a block of 26 benzodiazepines including diazepam (marketed under the trade name of Valium, among others), chlordiazepoxide (Librium), and nitrazepam (Mogadon) be brought under Schedule IV of the 1971 Convention on Psychotropic Substances. However, following a protracted and sometimes heated debate, the commission fell short of the 20 (out of 30) affirmative votes required for scheduling.

The call for block control was led by delegates from Malaysia and Nigeria who appeared to have solid backing from representatives of developing countries at this commission of the UN Economic and Social Council.

The debate, however, was diverted as the United States invoked a procedural right for a substance-by-substance vote as opposed to the WHO's total block. The ensuing argument prolonged the debate and forced a weekend adjournment.

Some observers believed this was a tactical victory for those opposed to the WHO recommendation; the weekend permitted continued lobbying by delegates and representatives of the pharmaceutical industry. While an early vote may have succeeded, the delay proved to be fatal with two absences and several crucial abstentions from developing countries that are hurt most by the widespread misuse of the benzodiazepines.

The five European Economic Community members on the commission (Belgium, France, Federal Republic of Germany, Italy, and the United Kingdom), who are also among producers of these drugs, solidly voted against the inclusion of the benzodiazepines in a block under the convention.

The US, traditionally a leader in the commission, and a strong advocate of international drug control, argued it had adequate information on only 13 benzodiazepines, eight of them on the WHO list of 26, and resisted a block vote.

Jean-Paul Smith, assistant director, international activities, the US National Institute on Drug Abuse, and a member of the US team, later told **The Journal**: "We were in favor of a drug-by-drug vote as a consideration of the benzodiazepines. That was the position we had going into the meeting.

"Our basic reasons were that it's sound science, sound health policy, that many of these drugs may never be abused, and, therefore, they shouldn't be controlled if they're not abused, or are not very likely to be abused," said Dr Smith.

"The fact is the commission talks about control of drugs on a drug-by-drug basis. All previous control actions (at the commission) have been on specific compounds, not on classes.

"We were operating on the precedent that was set earlier by the commission and by the international community. It would have been a very significant departure had there been a group consideration and control action taken."

The benzodiazepines have a variety of functions such as anti-anxiety, anti-convulsant, and sedative-hypnotic but are similar in structure and in pharmacological action. Their therapeutic value has been well established.

However, as early as the 1971 Plenipotentiary Conference in Vienna (which adopted the convention), the need for control had been discussed but postponed until more relevant data had been generated.

In 1981, the WHO stressed the need for a fresh look at these drugs in view of information that had become available on the potential of misuse. The commission decided

Smith: it's sound science

to consider the issue this year after further review by the WHO.

In the past few years, increasing concern has been expressed about rising benzodiazepine abuse especially among women, the elderly, and the chronically ill. This is reflected in a publication by Health and Welfare Canada entitled *The Effects of Tranquilization: Benzodiazepine Use in Canada*, by Ruth Cooperstock, Addiction Research Foundation of Ontario, and Jessica Hill, Health and Welfare Canada (**The Journal**, June, 1982).

The authors point to the "possibilities of impaired decision-making, decreased learning skills, released aggression, and impaired ability to empathize" which "have a significance beyond the lives of the individuals to the community at large." They also refer to the use of benzodiazepines to dull social pains and they emphasize the need to find other solutions.

Problems associated with the increasing use of benzodiazepines were also discussed at the 33rd International Congress on Alcoholism and Drug Dependence in Tangiers last October. Participants noted the need for further studies while pointing to the appearance of extensive abuse of benzodiazepines. Information from Thailand showed benzodiazepines were being used to enhance the effects of such drugs as heroin, amphetamines, and cannabis, and also to counteract or reduce the withdrawal syndrome of opiates. This was regarded as perpetuating drug dependence in that country.

Inclusion of the benzodiazepines in Schedule IV of the 1971 Convention basically requires licences for manufacture, trade, and distribution, and submission of reports on these activities to the International Narcotics Control Board. It also necessitates the drugs be dispensed only under a physician's prescription.

What worries the pharmaceutical industry is article 13 of the Convention, which is regarded by many as the strong point of the treaty. The article states "a party may notify all the other parties through the Secretary-General that it prohibits the import into its country . . . one or more substances," and "if a Party has been notified of a prohibition . . . it shall take measures to ensure that none of the substances specified in the notification is exported to the country."

While the vote appeared to have dampened the spirits of a number of delegates, a resolution was later passed requesting the WHO "to conduct a review and assessment of all benzodiazepines on the market" on a substance-by-substance basis and for this information to be transmitted to member states through the United Nations for consideration at the next session of the commission.

Benzodiazepines: back to the WHO laboratories

Canada lobbies for review

TORONTO — Canada was instrumental in drafting the compromise resolution that will keep benzodiazepines under the active scrutiny of the United Nations Commission on Narcotic Drugs.

Passed by the commission in Vienna, the resolution calls on the World Health Organization (WHO) to re-examine all the benzodiazepines on the market on a substance-by-substance basis, with a view to eventual control of the drugs under the 1971 UN Convention on Psychotropic Substances.

Members of the Canadian observer team at the commission meeting had favored a move by the WHO to have a block of 26 benzodiazepines scheduled under the Convention.

However, when this motion failed (see related story), Canada became one of the countries pressing for continued examination of the benzodiazepines.

Don Smith, senior scientist, Intergovernmental and International Affairs, Health and Welfare Canada, and a member of the Canadian observer team,

Smith

LeCavalier

says Canada's position has been, and still is, that the substances should be scheduled as a class under the convention.

He told **The Journal** criteria should be established to allow exemptions from the list afterwards. (This would, for example, shift the onus of showing a particular drug need not be controlled to the pharmaceutical industry.)

However, said Dr Smith, Canada was prominent in gathering sponsors for the substance-by-substance review after the initial vote was lost. It was a compromise to keep the drugs under consideration.

"The vote was not what we wanted, but this resolution redeems it in terms of getting it re-examined as a matter of urgency," said Dr Smith.

Jacques LeCavalier, director Bureau of Dangerous Drugs, Health and Welfare Canada, and another member of the Canadian team, was one of the prime movers in lobbying member countries to sign the resolution.

He told **The Journal**: "It was an idea that occurred to a number of countries. It started with five: Canada, Nigeria, Malaysia, the United States, and Sweden."

The compromise resolution was finally signed by 20 countries, he added, with one asking that its name be added when the issue was raised on the floor.

Mr LeCavalier said the job of reviewing each benzodiazepine will take considerable time because there are so many of the substances in existence.

"The most rational way of looking at that is to stop the clock at any time and review what's on the market on a substance-by-substance basis. And if there's an ability to differentiate, we'll include those substances which present a hazard or dependence-potential and exclude the others."

Drugs threaten all levels of US business world

TORONTO — Alcohol and drug abuse in the United States business world is growing at "an alarming rate" and costing an estimated $24 billion annually.

About two-thirds of all workers are using mood-altering chemicals ranging from alcohol through prescription medication to street drugs. One in 10 have abuse problems.

Many managers who are drinking heavily also come to depend on some type of pills despite well-publicized warnings about mixing liquor and drugs. However, this is "an equal opportunity problem" extending from the keypunch department up to the executive suite, says an article in *Datamation* magazine (Feb, 1983).

Jonathan Peck, a Massachusetts management consultant, says in the article the effects of drugs in data processing departments "is particularly evident among people who do programming work. Walk in on any one of those night-shift places, and they're in there — smoking (marijuana) usually. Half of them are stoned out. A lot of that goes on."

He also claims that cocaine is becoming a bartering tool in contract negotiations. "You go into certain offices in this country today and instead of sitting down and having a martini, you sit down and have a snort of coke."

Alcohol and drugs are being used both to help alleviate boredom and manage job pressure, the article says.

In a study of 149 companies, 25% of the firms with low or low-to-moderate pressure levels experienced employee drug use problems compared to 40% at companies where job pressure was higher.

This widespread abuse results in lower productivity among workers, increased lateness and absenteeism, and unnecessary turnover, the article says. Abusers have four to six times more on-the-job accidents and use twice as many accident and sick benefits as non-abusers.

One solution is employee assistance programs (EAPs), the article says, because they have an overall success rate of 70% and, when compared to the costs of not having them, are "one of the great all-time bargains in the corporate world."

US wants friendly nations' help to bring drug abuse under control

WASHINGTON — The United States House of Representatives Select Committee on Narcotics Abuse and Control will explore ways the government can work with friendly nations to control production and trafficking of drugs.

Congressman Charles Rangel, who was named chairman of the committee, which was reconstituted by the new Congress and expanded from 19 to 25 members, said international cooperation is "absolutely essential to bringing drug abuse under control."

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Toronto findings confirm earlier zimelidine work

I read with great interest your article on the results of the study conducted at the Addiction Research Foundation on zimelidine and alcohol drinking (**The Journal**, Dec, 1982). I found the results it reported exciting and promising.

I thought your readers may find it interesting to know that similar studies have been carried out in several other laboratories. My colleagues and I have been carrying out studies on the effects of zimelidine on alcohol drinkers for the past two years. In fact, to date we have completed three studies with human subjects.

The first of these studies demonstrated that the interaction between zimelidine and alcohol (1 gm/kg) did not yield any deleterious side effects.

The second study revealed that three, weekly administrations of zimelidine resulted in diminished drinking and desire to drink in social drinking.

The last study completed in July, 1982 was a long-term study where the effects of three months continuous administration of zimelidine resulted in a long-lasting reduction in voluntary consumption of alcoholic beverages.

It is indeed exciting to see that scientists in a different setting could independently confirm the results of our study. We can only hope that these combined efforts will yield significant findings in developing new treatment approaches to alcoholism.

Z. Amit
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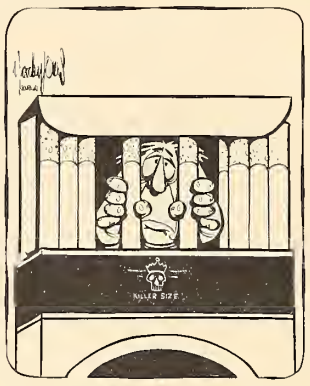
E. Ann Sutherland
Adjunct associate professor
Center for Research on Drug Dependence
Concordia University
Montreal, Quebec

Corporate anti-smoking campaign will use cartoon



We adore Yardley Jones' cartoon in the February issue of **The Journal.** Permission is requested to use this as a mail-out poster in our corporate-wide blitz on smoking behavior.

D. R. Henry, PhD, C. Psych
Section Head — Employee Assistance
Health Services Department
Ontario Hydro
Toronto, Ontario

Explicit story may assist disadvantaged workers

Thank you for the article (**The Journal**, March) on the Program for the Employment-Disadvantaged (PED).

The story was very explicit as to the purpose of the program, and it was a pleasure briefing you on that subject.

I hope that with support of associations such as yours, an even larger number of disadvantaged people will be placed in employment next year through the help of the PED.

Suzanne des Rivières
Employment and Immigration
Ottawa
Canada

Many thanks for years of service

It is with regret that I cancelled my subscription to **The Journal** as of Dec, 1982 since I am in retirement now. I want to thank you for the many years of service rendered.

I undertook that **The Journal** would stay in Holland, and have found a colleague who wishes to take over my subscription. I have passed on my 1983 issues to him.

J. Henselmans
Enschede
Netherlands

Kimberly leading UK alcohol group

Your report (**The Journal**, Jan) rightly draws attention to the uncertain position of the British National Council on Alcoholism (NCA) and Lord Kimberley's fight to prevent the government withdrawing its financial support.

Lord Kimberley has recently taken over as chairman on the NCA. Under the direction of its former chairman, the NCA was always involved in the internecine quarrels of the several voluntary organizations which do more harm than good in the British alcoholism field.

Lord Kimberley is now 11 years sober and by far the best person in this country to lead the fight to prevent alcoholism.

Ronald Forbes
Hon Executive Director
ALFAWAP Trust Fund Limited
London England

Reports conflict

In face of the massive research that has been done on cannabis, reports of some of which appear in **The Journal**, (eg Jan), how do you justify publication of the (Dick) MacDonald near-apologia for the use of the stuff in the January issue?

J. Gray
Calgary, Alberta

TJ will help 'tackle problem'

I have heard much about your valuable work. I would be very grateful if you would put me on your mailing list. We are just beginning to tackle the problem of addiction and need all the professional help we can get.

Rev Gerard Dunn
Glasgow, Scotland

The Journal **welcomes Letters to the Editor. Letters may be sent to the Editor,** *The Journal,* **33 Russell Street, Toronto, Ontario Canada M5S 2S1.**

REPORTS

Education is helping but problem still not solved

US surveys show decline in marijuana use

By Harvey McConnell

WASHINGTON — There has been a significant drop in marijuana, alcohol, and some other drug use in the United States, but an increase in heroin and cocaine overdose cases.

The trends are found in two, major, nationwide studies — the national household survey of drug abuse, and the national high school senior survey — carried out for the National Institute on Drug Abuse (NIDA).

Heroin and cocaine overdose increases in the first nine months of 1982 have been compiled by NIDA's drug abuse warning network (DAWN) and a six-month survey by the Drug Enforcement Administration (DEA).

The national household survey shows 33% of those questioned and aged 12 years and more have used marijuana, hallucinogens, cocaine, heroin, or psychotherapeutic drugs for non-medical purposes at some time in their lives. Approximately 19% have used one or other of the drugs in the 12 months before they were surveyed.

The national high school senior survey shows daily marijuana use declined for the fourth successive year: from a high of 10.7% in 1978 to 6.3% in 1982, the same figure recorded when the surveys began in 1975. (**The Journal**, Feb, 1982.)

The two surveys show rapid rises in cocaine use among young people have levelled off, although there is a slight increase in cocaine use by adults older than age 26.

Alcohol use among the seniors has remained at a steady point over the years, although there has been a decline of use in the general population. The numbers who smoke cigarettes have fallen.

The heroin overdose increase is ascribed to greater potency of the drug for sale on the streets.

Cocaine overdoses have risen as more people change the route of administration: from snorting to intravenous injection, combining cocaine with heroin (speedballing), or smoking cocaine (freebasing).

In the first nine months of 1982 there were 9,139 heroin overdose admissions to hospital emergency rooms in 26 metropolitan areas (some 20% of all US hospitals) covered by the DAWN system. This is a 33% increase over the comparable 1981 period.

Cocaine overdose admissions recorded by DAWN were 4,615 for the same nine-month period: more than all cases recorded in 1981.

A six-month survey in mid-1982 by the DEA found a dramatic increase in cocaine overdoses in six cities, ranging from a 36% increase in New York to a 90.4% increase in Los Angeles.

Although figures for 1982 from 86 medical examiners are not yet tabulated, it is known there has been an increase in heroin and cocaine overdose deaths.

Edward Brandt, assistant secretary for health, department of health and human services, in releasing the figures, said the results are encouraging but "the drug abuse problem among United States youth is far from solved."

Dr Brandt noted that US youth "still have the highest levels of illicit drug use to be found in any nation in the industrialized world."

Richard Schweiker, past secretary of health and human services, said much needs to be done "but in spite of all the pressures and all the temptations, young people can learn the facts about drug abuse and alcohol abuse, and reject the self-destructive choices that have been on the increase for years."

Lee Dogoloff, executive director, American Council on Marijuana (ACM) and for 2½ years national policy staff advisor on drugs under former president Jimmy Carter, said: "The figures show that education really makes a difference, in that given good health information, people will change their behavior. I think it shows also that the collaboration between government efforts and the parents' movement and professionals, all working together, which began in the late 1970s under president Carter, is really beginning to show results. The present administration is carrying out these programs and it shows it is the right thing to do."

Dr Robert DuPont, president of the ACM and former director of the NIDA said: "I am pleased with the marijuana use decline but I think the biggest concern I have is that the decline is going to be over-interpreted. It is what I call primary process thinking: if it's going up it's terrible, if it's going down it's bliss. That's the way people react to headlines."

Household survey

The national household survey on drug use is carried out every two or three years from a national sample of households by a team, headed by Ira Ciscin (PhD), George Washington University, Washington, DC.

The 1982 survey, the seventh since they began in 1971, involved 5,624 people among three populations: youth (12 to 17 years), young adults (18 to 25 years), and older adults (26 years old and more).

The survey found significant declines among both youth and young adults for any use of marijuana in the preceding year and for current use of the drug.

Marijuana use during the past year dropped from 24% in 1979 to 21% in 1982 among the youth, and from 47% to 41% among young adults.

Current use of marijuana dropped from 17% in 1979 to 11% in 1982 among the youth, and from 35% (an all-time high) to 28% for young adults over the same period.

The survey said the current use figures reflect the patterns of behavior being found today among young people.

The 1982 survey introduced a new measure to try to gauge the number of people who have used marijuana on a daily basis for some period in their lives.

Twenty per cent of those questioned said they had at one time used marijuana daily. "Clearly, despite reduced levels of current marijuana use in 1982, many young people pass through one or more phases of concentrated use, and during this time they are at risk for various negative consequences."

There has been a downward turn in use of hallucinogens, including LSD, PCP, and peyote. The same appears true for heroin, although the study said this may reflect a tendency by some people to deny such stigmatized behavior.

Cocaine use increased rapidly during the 1970s but seems to have stabilized.

Among young adults, lifetime experience of cocaine rose from 13% in 1976 to 28% in 1979, and in 1982 appears to have levelled off at 29%.

Past-month use of cocaine in young adults jumped from 2% in the mid-1970s to 9% in 1979. It moved to 7% in 1982.

In older adults, past-month use of cocaine rose from 0.9% in 1979 to 1.2% in 1982. This had been expected by researchers as young adults moved into the older adult category in the intervening three years.

In all three age groups, the survey found the prevalence of non-medical use of psychotherapeutic drugs is comparable to the prevalence of cocaine use.

When non-medical use of psychotherapeutic drugs is combined in a single index with the use of hallucinogens, cocaine, and heroin, the survey found about 40% of all young adults have had experience with at least one illicit substance other than marijuana. About 27% of this age group report past-year use of one or more of these drugs.

Among the youth group, 14% have tried one or more of the drugs, and 10% have used during the past year.

Among youth, alcohol use during the month prior to the survey dropped from 37% in 1979 to 26% in 1982. Among young adults the drop was from 76% to 68% over the same period.

As for the use of alcohol on 20 or more days during the past month, in young adults this declined from 10% in 1979 to 7% in 1982: this directly parallels the drop in current daily use of marijuana.

Past-month cigarette use among youth remained stable at 12% between 1979 and 1982, but among young adults it dropped from 43% to 38%, and among older adults from 37% to 34%.

High school senior survey

The national high school senior survey is conducted annually from a national sample of high school seniors by Lloyd Johnston (PhD), and colleagues of the University of Michigan. The 1982 survey involved 17,700 seniors from public and private schools.

Between 1981 and 1982, nearly all classes of illicit drug use showed declines. The largest drops were for marijuana, cocaine, stimulants, and sedatives.

Tranquillizer and hallucinogen use showed more modest declines, and cigarette use has now levelled off after reaching peak levels in the late 1970s.

But, the report adds: "Despite this generally good news about the direction which things have been moving, it would be a disservice to leave the impression that the drug abuse problem among US youth is anywhere close to being solved."

The report says it is still true:

- Roughly two-thirds of all young people in the US (64%) try an illicit drug before they finish high school.
- More than one-third have used illicit drugs other than marijuana.
- At least one in every 16 high school seniors is actively smoking marijuana on a daily basis, and fully 20% have done so for at least a month at some time in their lives.
- Some 30% have smoked cigarettes in the prior month, a substantial proportion of whom are, or soon will be, daily smokers.

The survey found marijuana use has shown a consistent decline since 1979. While the proportion of seniors who have ever tried the drug hovers around 60%, current use has dropped considerably: from 37% in 1979 to 29% in 1982.

The most striking decline has been in daily, or near daily, marijuana use, which rose from 6% to 11% between 1975 and 1978 and has now dropped to 6.3%. This is attributed to increasing concern among young people about the health consequences of regular use and less peer acceptance of such behavior.

Some 60% of high school seniors now attribute great risk to regular marijuana use compared with 35% who felt the same in 1978. And 75% of seniors now believe their friends would disapprove of such behavior.

Annual cocaine use doubled between 1975 and 1979 to 12.4% and has fallen to 11.5%. The first decline was seen in 1982 of methaqualone use, from 7.6% to 6.8%, in the past year.

The use of PCP during the previous year dropped from 7% when first recorded in 1979 to 2.2% in 1982.

Annual use of LSD remains at 6.1%; amyl and butyl nitrite use has declined to 3.6%.

Annual prevalence of heroin use has remained stable with 1% reporting they had ever used the drug. The survey notes this is probably an under-estimation because of the perception of heroin as "more illicit."

Stimulant use began to show a gradual increase starting in 1979 when use during the past year was reported by 26% of the seniors and daily use was 1.2%. The figures were more or less the same for 1982.

However, the survey said the increases have probably been exaggerated — perhaps sharply exaggerated — by respondents' inclusion in their answers of non-amphetamine, over-the-counter diet and stay-awake pills, as well as look-alike and sound-alike pills.

Revised questions about true amphetamine use were added in 1982 but it will only be after the 1983 figures are studied that trends may be spotted.

Sedative use declined to 9.1% for use in the last year, the lowest level yet.

The survey again found that daily alcohol use has remained steady. The figure for 1982 — 5.7% — is the same as recorded in 1975.

The survey adds: "To answer a frequently asked question, there is no evidence that the currently observed drop in marijuana use is leading to a concomitant increase in alcohol use.

"If anything, there may be some parallel drop in alcohol use, just as there was some parallel rise in earlier years."

The proportions of high school seniors smoking half a pack or more of cigarettes a day was 14.2% in 1982 and the proportion reporting daily use at any level was 30%.

Declines in cigarette use parallel those in marijuana use and for the same reasons: personal concern about the health consequences of smoking and perceived peer disapproval of regular use.

Use of any illicit drug among males rose to a high of 59% in 1978 and has declined to 52% in 1982. Among females it rose to 51% in 1981 before dropping to 49% in 1982.

However, if figures for amphetamine use are deleted, female drug use peaked in 1979 and has continued to decline.

The most striking decline has been in daily use of marijuana

INTERNATIONAL

Hong Kong moves to protect smokers and non-smokers

By Lachlan MacQuarrie

HONG KONG — A smoker who lights up in a public place in Hong Kong, or in a place designated as a no-smoking area, now faces a fine of HK$1,000 (Cdn $200).

This is one of the provisions of Hong Kong's newly-promulgated Smoking (Public Health) Ordinance, 1982, given final reading by the Legislative Council recently. The ordinance provides for restrictions on smoking in public areas and requires cigarette packages and tobacco advertising to carry health warnings and tar-group ratings.

A fine of HK$5,000 (Cdn $1,000) is to be imposed on anyone who sells, or is responsible for selling, cigarettes in packages not bearing, in Chinese and in English, both the health warning and the Hong Kong government-determined tar-group rating. The English text of the health warning will read, "Hong Kong Government Health Warning: Cigarette Smoking is Hazardous to your Health."

A similar fine of HK$5,000 faces anyone responsible for any cigarette advertisement — indoor or outdoor, on television or radio — which does not carry this warning, and a further penalty of $500 per day will be imposed for each additional day the offence continues.

The ordinance also prohibits smoking in a number of public places. At least 50% of each class of seating in movie theatres, concert halls, theatres, railway trains, and ferries in Hong Kong must now be designated as no-smoking areas, and a manager who does not set aside these no-smoking areas and fails to display appropriate no-smoking signs is liable to a fine of $5,000.

Smoking will also be prohibited in elevators, and all public transport except taxis.

Introducing the legislation, Hong Kong's Deputy Secretary for Social Services, Geoffrey Barnes said its purpose is to protect the health of both smokers and non-smokers, and he pointed to the continually rising incidence of lung cancer in Hong Kong.

Mr Barnes said the rate of lung cancer deaths per 100,000 has risen by 26% since 1975, and actual deaths have gone up by 48%. There is also an increase of 25% in lung cancer as a percentage of deaths from all causes.

"In the face of the increasing problem posed by lung cancer, and the public support for anti-smoking measures shown by a public opinion survey last year, stronger action is clearly called for."

Cigarette packages, advertisements will have to carry the new Hong Kong government warning

Mr Barnes also announced government plans to procure a machine to measure the amount of tar and nicotine in different brands of cigarettes, most of which are manufactured in China or in the United States. Test results will be published twice a year in the Hong Kong Consumer Council's magazine and in newspapers.

Mr Barnes dismissed claims by the local tobacco industry that the Hong Kong government's anti-smoking drive amounted to curbs on personal freedom. "We are not legislating to restrict freedom of choice. If anything we are legislating for a greater freedom of choice."

The requirements of the new ordinance are being introduced in three stages to permit cigarette manufacturers, advertisers, managers of public facilities, and the general public to comply. Already in effect are provisions that newspaper and magazine advertisments must carry the government health warning and tar-group rating.

The second stage, now under way, involves the designation of no-smoking areas, prohibition of smoking in public transport, and mandatory warnings for all other forms of cigarette advertising including neon signs and television commercials. The final stage, to commence in August, will require that all cigarette packages sold in Hong Kong must carry the health warnings and tar ratings.

Soviets tackle huge problem of alcohol use

TORONTO — The Soviet Union is cracking down on the drinking habits of its citizens.

Since November, Soviet television, radio, and newspapers have been attacking alcohol and weaving it in with a campaign against loafers and stealers of state property.

The central committee of the Communist party has called for stronger laws dealing with these "subversives" to try to solve the country's immense drinking problem. One Soviet affairs analyst claims almost 50,000 people a year die from alcohol poisoning.

Soviet citizens have been warned of the dangers of drinking even one or two glasses of wine regularly because it could lead to alcoholism.

A doctor has also advised that consumption of alcohol outdoors when the weather is cold is "absolutely ruled out," says a report in *The Toronto Star*.

However, Russian rulers since Peter the Great have had to deal with the dilemma that alcohol does provide some benefits to the country.

Taxes from the sale of vodka still provide much of the revenue of local councils. However, that has to be balanced with the cost of massive drinking to the modern industries and the extensive health service of the Soviet Union.

PLEIDLEISIWCH

YN ERBYN

AGOR Y TAFARNAU AR Y SUL

PAM?

Mae alcoholiaeth ar gynnydd
a gall eich niweidio
mewn sawl ffordd.

1. **Damweiniau**—ar y ffyrdd.
   Gall ladd.
   Mae'n lladd — bob dydd, bob wythnos.
   Gall **gormod** fod yn **ychydig.**
2. **Effeithiau Cymdeithasol**
   (i) Gwaith—Mae diwydiant yn colli mwy oherwydd **diod** nag a gyll oherwydd **streiciau.**
   (ii) Cartref—Curo plant; curo gwragedd; yfed pwrs y teulu.
   (iii) Plant—Gall plant a enir i rai a fu'n llymeitian gael eu geni â nam arnynt. Gelwir yr anghaffael yn "Foetal Alchohol Syndrome".
3. **Dibyniaeth**
   Mae alcohol yn gyffur.
   Gall rhai fynd yn ddibynnol arno—mynnir fod rhyw filiwn o alcoholiaid cofrestredig ym Mhrydain.
   Am bob un hysbys, y mae rhyw **bump** anhysbys—pum miliwn i gyd.
   Dwywaith poblogaeth Cymru—yn **gaeth** i'r botel!
4. **Y Sul**
   Bu'r Sul Cymreig o werth.
   Mae'r Sul Cymreig o werth.
   Diogelwn ei werth mewn dyddiau o densiwn.

CHWI SYDD I BENDERFYNU PA FATH O GYMRU A FYNNWCH. BWRIWCH EICH PLEIDLAIS WEDI YSTYRIED.

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WHAAA . . .?

Vote Against Sunday Opening — Why? reads the title of this leaflet in Welsh distributed by the Welsh National Committee Against Sunday Opening (of public houses). Following a recent referendum held in 16 of 37 districts in Wales, however, only two districts remain convinced. Prior to the vote, six districts had been dry for 101 years. Four of those opted for the opening. Ten others, already wet, decided to stay that way.

Alcoholism epidemic predicted for Britain

By Jane Corrigan

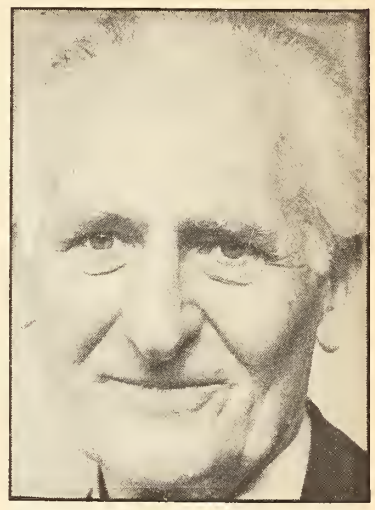
LONDON — Britain has been told to expect a new epidemic of alcoholism within the next decade.

Making the prediction, Sir Richard Doll, director of the UK's Imperial Cancer Research Fund's epidemiology unit, calls for the establishment of an anti-alcoholism campaigning body similar to ASH, (Action on Smoking and Health) the anti-smoking organization (**The Journal**, Sept, 1982).

Reducing the average amount consumed by the whole population may be brought about most simply by increasing cost relative to income, Sir Richard said. "But we should not despair of other methods."

He said the policy of the new body should be actively to encourage light drinking because of the "strong, if not quite conclusive evidence that a daily quota of one or two pints of beer or a few glasses of wine reduces the risk of death from cardiovascular disease."

In his Harveian Oration given at the Royal College of Physicians and reprinted in the *British Medical Journal* (Feb 5, 1983) Sir Richard also said it remained to be proved whether it was possible to mitigate the worst effects of smoking by using tobacco other than in cigarettes.



Sir Richard: a daily quota of one or two pints.

Methodist ministers drinking more, say abstinence is a social barrier

LONDON — More Methodist ministers in Great Britain now drink than did 20 years ago, says a survey by the Christian Economic and Social Research Foundation.

The number of drinkers has climbed to 42.9% compared with 29.3% in 1972 and 9.9% in 1962.

Rev George Thompson Brake, the foundation's honorary director, says the permissive attitudes of the 1960s may be one reason for the increase in drinkers, especially among ministers who grew up then.

However, many of the ministers who answered the survey said they found abstinence a barrier to social contact, says an article in the *Alliance News*.

Mr Brake finds that reason hard to swallow and believes the ministers' embarrassment has more to do with lack of self-confidence in unfamiliar situations.

"If there are sound reasons for not being an abstainer let these be respected, but not the kind of 'cop-out' reasons I have read in some replies," he says. "It would be better to hear the honest, if regrettable, reason — I like it."

A people in crisis

Survival of Maoris is threatened by alcohol

By Tony Garnier

WELLINGTON, NZ — The high level of alcoholism among New Zealand Maoris threatens the survival of the race, a preliminary study says.

The study's findings were reported at the 10th biennial summer school of the New Zealand National Society on Alcoholism and Drug Dependence (NSAD) held here recently.

Describing the Maori race as "a people in crisis," Rev Hemi Ransfield of Auckland, himself a Maori, said he couldn't overstress the critical situation Maoris face.

"I am absolutely convinced if we don't address the problem of alcoholism, we will ultimately self-destruct."

The level of alcohol and other drug abuse among Maoris poses a threat not only to individuals "but to the very survival of our Maori race," said Mr Ransfield, a Baptist minister.

Maoris comprise the largest group of non-European New Zealanders; about 10% of the population of 3.25 million. (A Maori, by definition, is anyone of Maori descent, wishing to be identified as Maori.)

A further 200,000 New Zealanders consider themselves part-Maori, part-European, but were not included in the study.

Mr Ransfield used five criteria for assessing alcoholism — health (physical and psychological), familial, occupational, legal, and financial.

His premise was that if an individual presented problems in any of these areas and was using excessive amounts of alcohol, he or she had an alcohol problem.

He found that the Maori people were over-represented in every category, and were, in individual assessment terms, at the "chronic" phase of acute alcoholism.

Mr Ransfield found Maoris have a life expectancy of 10 years less than non-Maori New Zealanders, and a birth-mortality rate three times higher.

Maoris have greater susceptibility to disease, various forms of cancer (Maori women have the highest lung cancer rate of measured ethnic groups), and heart and pulmonary problems.

Although Maoris are only 10% of the population, they comprise 25% of the inmates of New Zealand's mental institutions and 40% of prison inmates.

Children and youth involved in solvent abuse are at least 60% Maoris. "Street kid" is a term very familiar to Maoris, who are generally unskilled and have a high unemployment rate.

Mr Ransfield said while Maori value systems differ in some ways from the non-Maori population, Maoris are basically poorer. Many are dependent upon the extensive welfare system — drawing an unemployment benefit, family benefit, and/or domestic-purpose benefit as the sole income source.

Maori community workers have known alcoholism is the major problem in Maori families.

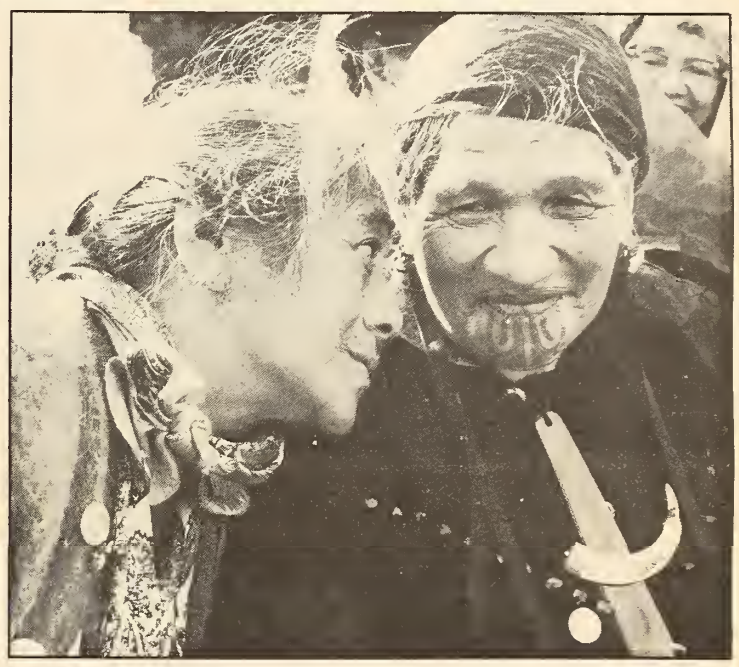
Mr Ransfield says many Maoris today believe they are inferior to non-Maori New Zealanders. This attitude has become ingrained and universal as a result of the long cultural contact with Europeans, some of whom seemed to believe they "are superior."

These feelings of inferiority make the Maori a vulnerable target for alcoholism.

Mr Ransfield: "It is this kind of (attitude) which has perpetuated much of the tragedy we are confronted with today. It is a greater tragedy because of the invalidity and belief in something so utterly untrue, and (because) it was encouraged by the *Pakeha* (early European settlers), who had more to gain. The most effective encourager was alcohol."

Maori community leaders plan their "own recovery," said Mr Ransfield, including seeking assistance from government agencies — health, justice, social welfare, and Maori affairs.

Maoris, living and working side-by-side with their European countrymen, are vulnerable targets for alcoholism, disease, and poverty



New drinking patterns are emerging in New Zealand

Beer is still popular but wine gains new following

By Tony Garnier

WELLINGTON, NZ — Although many New Zealanders complain constantly about the rising cost of liquor, a survey has revealed it's relatively cheaper to drink now than it was 10 years ago.

Ten years ago, the average wage earner worked 18 minutes to earn enough for a jug of beer. Now he has to work only 12 minutes — five jugs an hour.

In 1971, it took 9.2 minutes to earn enough for a nip of whiskey. Now it takes only 6.9 minutes. And it takes only 5.5 minutes to earn enough for a gin, against 7.1 minutes in 1971.

The updated figures were reported by Stephanie Duncan, research manager of the NZ Liquor Advisory Council, at the New Zealand National Society on Alcoholism and Drug Dependence 10th biennial summer school here. She also examined changes in the distribution of alcohol consumption in New Zealand.

Between 1968 and 1972 the proportion of drinking in hotels was virtually static, but the past 10 years saw a dramatic drop in the patronage of hotels and taverns. In 1972 one person in four consumed liquor in a bar. Today the figure is down to one in 10.

Changing lifestyles, increased affluence, drunk-driving blitzes by traffic officers, an increase in licensed sporting clubs, and increased drinking by women, are factors contributing to the change in drinking patterns.

While beer remained the most popular drink, wine moved ahead of spirits — largely because it was clearly the choice of most women drinkers. Wine has undergone dramatic changes, the survey revealed. "Today is the era of Chateau Cartonne — wine packed in plastic bags inside cardboard boxes. It is no longer found only on the dining table but draws crowds at barbecues."

The pilot survey says wine is usually consumed with a meal, but young people now regard it as a social drink that could replace beer.

While the survey was not regarded by the council as an absolute indicator, it did show "with some certainty," that compared with 1972:

- People are drinking more.
- Hotel patronage is down.
- Take-away trading via bulk purchasing is up.
- People are drinking more at home, or in homes of friends.
- Women are drinking more frequently.
- Women are drinking wine in preference to spirits.
- Dining-out has increased.
- Wine is largely being consumed with meals, but this pattern is changing.

Cost relativity (in NZ$)

	1971	1974	1982
Average weekly wage (gross)	NZ$53.61	$77.07	$252.45
Hourly rate	$1.44	$2.07	$6.88
Price of a jug of beer	$0.43	$0.48	$1.68
Price of a nip of whisky	$0.22	$0.25	$0.79
Price of a nip of gin	$0.17	$0.20	$0.63
Time taken to earn a jug of beer	18 min	14 min	12 min
Time taken to earn a nip of whisky	9.2 min	7.2 min	6.9 min
Time taken to earn a nip of gin	7.1 min	5.8 min	5.5 min

Rapid rise in drug abuse alarming Irish experts

DUBLIN — Doctors here are unable to keep pace with the alarming increase in drug abuse among Ireland's youth.

Michael Kelly, a consultant psychiatrist and director of the Drug Advisory and Treatment Unit here, says he and his staff are now handling more than 200 cases of heroin abuse a month. Three years ago the unit handled about 10 a month.

"We're not coping. We've had to discharge hepatitis cases onto the street," Dr Kelly says in an article in *Hospital Doctor*, a United Kingdom publication. "We're trying to get extra beds to deal with these cases, but at the moment we just cannot take the number of people we want to."

Those taking drugs are from every socio-economic class and as young as 13 years old, he says. Some have been seen in the city's streets injecting themselves or sniffing glue.

Drugs are brought into Ireland by organized crime and large numbers of young people. They are a part of a new unemployed group, some with college degrees, who see importing as a way of making money.

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NEWS

Drinking drivers more susceptible to serious injury

By Rhonda Birenbaum

OTTAWA — A North Carolina survey of more than 14,000 automobile accidents has confirmed the higher the driver's blood alcohol level, the greater the probability he will be seriously injured or killed.

Patricia Waller (PhD), of the University of North Carolina Highway Safety Research Center in Chapel Hill, found a "consistent and positive" relationship between alcohol and driver injury.

"Given approximately the same damage to the car, and approximately the same conditions, drivers with higher blood alcohol levels were more likely to be seriously injured or killed," Dr Waller said.

"Alcohol-impaired drivers were involved in a higher proportion of serious crashes than were control (sober) drivers," she told the annual meeting of the American Association for Automotive Medicine here. About 5.5% of the crashes involving an intoxicated driver resulted in a fatality, whereas only 0.5% of crashes of sober drivers did.

In addition, 18.7% of the alcohol-impaired drivers were seriously injured compared to 8.7% of the sober drivers. Likewise, the alcohol-impaired had a higher proportion of seriously-damaged vehicles compared to the sober group.

Speed prior to the crash also related to the presence of alcohol. "About 35% of the intoxicated drivers' crashes were at speeds of 60 mph (100 kmh) or greater, whereas only 11% of the control (sober) drivers' crashes occurred at these high speeds," she said.

All of the accident data were analyzed on the basis of a dozen descriptive variables. Dr Waller found the drinking group differed from the sober group on all 12 parameters investigated, including hour of day, day of week, time of year, age and sex of driver, model of car, single or multiple crash involvement, point of contact of vehicle, safety belt use, speed prior to crash, degree of driver injury, and type and amount of damage to the vehicle.

From the results, she drew a detailed profile of alcohol-impaired drivers which related crash characteristics and driver injury to the presence of alcohol: alcohol-impaired drivers were more likely to have crashes between 6 pm and 6 am, on Saturday and Sunday, and in clear weather than were sober drivers.

Most drinking drivers were male, aged 20 to 44 years, and driving older model cars (more than six years old). They were also more likely to be involved in single vehicle crashes and to have neglected to wear seat belts, she said. A greater proportion of intoxicated drivers did not hold a valid licence.

Interestingly, Dr Waller also noted: "As the blood alcohol level increases, the proportion of high speed crashes decreases but with a corresponding increase in the percentage of drivers seriously injured or killed. More of the drinking drivers died even though their injuries were no worse than those of sober drivers," she said.

In light of this apparent association between intoxication and decreased recuperative power, Dr Waller suggested a highly-intoxicated person may succumb more readily to the same degree of injury than would a sober person. She pointed to several animal studies which supported this relationship between alcohol ingestion and poor wound healing.

"It appears that drinking drivers (and animals) may be less likely to survive the same bodily injury," said Dr Waller, contradicting common folklore that the intoxicated person is more relaxed and, hence, more likely to emerge unharmed from a crash.

Alcohol may make brain more vulnerable to injury

LAS VEGAS — Impaired drivers' brains may be more sensitive to blunt injuries than those of sober motorists, says a professor of anesthesiology and neurosurgery at the University of Texas Health Science Center at San Antonio.

Maurice S. Albin told the American Society of Anesthesiologists meeting here that his experiments with dogs showed that those given alcohol equal to four to six drinks an hour developed brain lesions from blunt cranial injury that were five times as extensive as a control group.

Dr Albin speculates that alcohol may disrupt cell membranes, thus spreading the area of brain injury, says an article in *Medical World News*.

Grants given to Canadian researchers

OTTAWA — Health and Welfare Canada has announced grants of more than $279,000 to three separate research groups studying various aspects of cigarette smoking, alcohol and marijuana.

Drs Charles Goldsmith, Anthony Kerigan, and David Pengelly of McMaster University in Hamilton receive $196,204 to study adolescents who smoke compared to those who don't. The researchers will try to determine what other environmental factors or previous respiratory problems contribute to the development of long-term respiratory difficulties.

Dr Peter Fried of Carleton University in Ottawa has been given $53,326 to continue research on the effects of alcohol, tobacco, and marijuana use by pregnant women. Dr Fried has found that marijuana use during pregnancy can affect the visual responsiveness of the baby.

He will attempt to determine how prolonged the effects are and whether marijuana use in early pregnancy constitutes a particular risk for the baby's vision.

The ministry has granted $29,710 to Drs Linda Pederson and Neville Lefcoe of the University of Western Ontario in London to conduct a six-year follow-up of cigarette smoking among a group of students.

The children were studied from grades 4 to 6, beginning in 1975. Follow-up work will shed light on developmental trends in smoking, on high-risk individuals, and on the process of initiation to smoking.

Nova Scotia hosts 1984 regional CAF meeting

TORONTO — Families and drug dependencies, new problems, will be the theme of the 1984 Atlantic regional conference of the Canadian Addictions Foundation, April 29 to May 3, in Halifax.

Conference host will be the Nova Scotia Commission on Drug Dependency, and co-sponsors, the commissions of the other three Atlantic provinces — New Brunswick, Newfoundland and Labrador, and Prince Edward Island.

Goodwin: shows by age 30

Early onset, severity typify familial alcoholism

By Lynn Payer

KANSAS CITY — Controlled drinking is not an effective treatment for sons of alcoholics, says Donald Goodwin. "The treatment for them is to stop drinking."

Dr Goodwin, chairman of the department of psychiatry, University of Kansas Medical Center here, told **The Journal** recent studies of people at high risk of alcoholism, strengthen the plea that "familial alcoholism" be recognized as a separate diagnostic entity.

"It's fairly well established that something's being transmitted biologically," he said. "We're trying to find out what is being transmitted."

Dr Goodwin cited a study in Denmark, in which sons of alcoholics had lower scores on the categories test of the Halstead Battery than did controls. They also generated more alpha rhythm — associated with feeling good — on their electroencephalographs after drinking alcohol.

Alcoholics, he said, fairly consistently have low scores on the categories test — a measure of abstract reasoning in which people being tested are required to grasp a principle illustrated by objects flashed on a screen.

Poor performance of alcoholics, Dr Goodwin explained, has usually been attributed to brain damage from drinking.

"But here you have their children, who don't drink much, also doing poorly on the categories test," he said. "The interpretation of the previous studies may need revision."

Dr Goodwin said the concept of familial alcoholism proposed by E.M. Jellinek has been neglected for many years. However, recent studies of concordance between identical and fraternal twins, as well as his own study of the children of Danish alcoholics, have tended to revive the concept.

Familial alcoholism, Dr Goodwin says, is characterized by an early age of onset and a particularly severe course.

"If you go to any hospital in the world with an alcoholism unit, you will find that the younger alcoholics have a positive family history (of alcoholism), and, in 90% of cases, if one family member is alcoholic, more than one is. The older alcoholics tend not to (have a positive history).

"If you have it in the family, if you're going to become alcoholic, you become it at a younger age. You can almost say that if you have it in the family and haven't become alcoholic by 30, you're not going to become alcoholic."

Familial alcoholism is also characterized by an absence of other conspicuous psychopathology, such as criminality, depression, and schizophrenia, he said.

However, Dr Goodwin said this characteristic was not as well established as early onset and severity in familial alcoholics.

Per capita consumption increases but proportion of smokers drops

OTTAWA — The proportion of regular smokers in the adult population (aged 15 and older) in 1981 was 33%, the lowest level in 15 years, according to the latest statistics from Health and Welfare Canada.

Between 1966, the year when the Labour Force Survey on the smoking habits of Canadians was introduced, and 1981, the proportion of men who smoke regularly declined from 54% to 36%. The prevalence of smoking among women in that same period dropped from 32% to 29%.

These figures are contained in the recently released report *Smoking Behaviour of Canadians, 1981.*

The report also notes the percentage of teenage boys regularly smoking declined by 35% in those 15 years to about 23%. The percentage of teenage girls who smoke regularly increased from 20% in 1966 to 28% in 1972 but has since dropped to 23% by 1981.

However, per capita consumption of cigarettes in Canada has increased slightly in those years despite the decrease in the number of smokers. In 1968, the rate was 3,703 cigarettes per person compared to 3,872 in 1981.

There is also a higher proportion of heavier smokers. In 1981, 13% of regular smokers puffed more than 25 cigarettes a day compared to approximately 10% in 1970, says the report.

However, they seem to be smoking lower-tar cigarettes, the report notes.

The report also says about 37% of all regular smokers surveyed had attempted to quit in the past year.

'Dissociators' less likely to tone down drinking

KANSAS CITY — Some heavy drinkers may have a stronger dissociation or separation of their drunken and sober states, suggest preliminary findings of a study here.

Donald Goodwin, chairman of the department of psychiatry, University of Kansas Medical Center, says previous studies have shown that when people learn something while drunk, they can recall it better when they're drunk again than when they're sober.

However, they have been one-time studies, and individual differences have been obscured by the overall group performance, he says.

Recently, repeated tests of a group of 12 medical students found three students consistently "dissociated" much more than the others. These three were heavy drinkers.

The separation worked both ways, Dr Goodwin says, with the dissociators tending to recall poorly when drunk things they had learned while sober, and vice-versa.

"No matter how many times you test them, it's consistent."

While emphasizing the numbers were as yet small, Dr Goodwin raised the possibility that such easy dissociation may be connected with a propensity to alcoholism.

"One of the chracteristics of alcoholism is it's a punishing disease," he says, "but the punishment of hangover and embarrassment come when you're sober."

While normal drinkers will tend to remember their punishments the next time they drink, and to moderate their drinking accordingly, dissociators may be less likely to, he says.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Margaret Sheppard, at (416) 595-6150.

The Great American High

Number: 544.
Subject heading: Drug use: etiology and epidemiology, attitudes and values, impaired driving.
Details: 57 min, 16 mm, color.
Synopsis: Ed Newman narrates this look at drug use in the United States with particular emphasis on how drugs other than alcohol are becoming more involved in traffic accidents. Statistics of use, interviews with users and those who have quit tell of alarming rates of drug use. The Armed Forces is beginning to realize that national defence is in jeopardy because of drug use among the military.
General evaluation: Fair (3.1). Although this contemporary film was made for general broadcast, the poor quality of production and length ruled it out as a good educational film
Recommended use: The review group said it would not be beneficial to any group.

Me and the Monsters

Number: 545.
Subject heading: Attitudes and values, trigger films.
Details: 9 min, 16 mm, color.
Synopsis: This animated film takes a young boy through a week of problems that he sees as monsters (friends leaving him, adults not being nice, etc). He dispells the monsters by believing other ways of behavior are possible.
General evaluation: Fair (3.4). The review group thought the message was too simplistic. However it put drug use in the context of everyday problems, and that was seen as a plus.
Recommended use: Of benefit to those from kindergarten to grade 3 as a discussion starter.

Nutrition and Alcohol

Number: 546.
Subject heading: Alcohol and nutrition.
Details: 28 min, 16mm, color.
Synopsis: We need certain chemicals to build our organs and keep us going. Alcohol affects our nutritional level by providing a substitute that fills us up but does not provide the necessary chemicals. Many diseases result from the substitution of alcohol for other foods.
General evaluation: Poor (2.0). The film was judged a poor teaching aid and boring because of its style of presentation (a lecture), and because of the inaccuracies (eg it is no longer recommended to give an alcoholic many small meals while detoxifying).
Recommended use: Should not be shown.

NEWS AND DEPARTMENT

PEI students are 'catching up' on marijuana use

CHARLOTTETOWN, PEI —There has been a "sharp increase" in the number of students here using marijuana, says a survey by the Alcohol and Drug Problems Institute Inc.

The report says 25% of Prince Edward Island students used the drug at least once in the past six months compared to 15% six years ago. In 1976, approximately twice as many students in other parts of North America used marijuana.

However, there has been little increased use reported in those other areas since then, and PEI students have now almost caught up with the North American average, the survey says. (See page 9.)

It states that while most users can be classified as experimenters, one in six smokes marijuana weekly, and one in 20 uses it daily. The number of daily users is more than twice what was reported in 1976.

The survey of 1,559 students from grades 7 to 12 was conducted last year by the private corporation for the province and is the third since 1972.

It found that alcohol continues to be the most popular drug among students; two-thirds reported having had a drink at least once in the six months prior to the survey. This is only a slight increase over the 1976 figures (64.5%).

However, twice as many students (26.3%) as in 1976 now report becoming inebriated at least half the time when they drink.

The survey also notes the only significant decrease in any drug usage in any grade since the last survey was for alcohol at the grade 7 level.

"It is interesting that (Queens County) Addiction Services on Prince Edward Island has directed its major educational thrust over the past several years at the grade 6 and 7 students," the survey says.

"Possibly, an increased effort of wider scope including tobacco, alcohol, and marijuana should be directed at other key grade levels by some agency or the school system."

Such a wider scope is needed in prevention programs because of the incidence of poly-drug use. The survey found students who smoke cigarettes daily are twice as likely to use alcohol and six times as likely to use marijuana as are non-smokers.

Students who drink weekly are 80 times more likely to use cannabis than non-drinkers (65.3% compared to 0.8%), the survey says.

"These correlations could be extremely important in prevention programs since one may infer that if the student can be discouraged from using tobacco, the incidence of alcohol and marijuana use could possibly decrease.

"Further, if students could also be discouraged from using alcohol on a frequent basis, the incidence of marijuana use could markedly decrease."

The survey found that 11% of the students used magic mushrooms (psilocybin) and 7.4% used oral stimulants such as amphetamine or other pep and diet pills. Magic mushroom use wasn't surveyed in 1976, but only 2.2% of students used oral stimulants in that year.

About 50% of the students smoke cigarettes which is up slightly from 1976. However, tobacco use in PEI is much higher than in other parts of Canada, such as Ontario, where only 30% smoke, says the report.

New Brunswickers drinking less, moving over from beer to wine

By John Carroll

FREDERICTON — Higher prices and taxes pushed per capita expenditures on alcoholic beverages to record levels in New Brunswick in fiscal 1981-82, but for the first time in years the actual amount consumed was down from the previous year.

The annual report of the New Brunswick Liquor Corporation (NBLC) for the year ended March 31, 1982, shows that New Brunswickers spent $226.56 per capita on alcoholic beverages. Total sales were $156,085,499 for a population of nearly 689,000. But in litres sold, the NBLC reported a 4.28% decline to 59,321,427 litres from 61,974,803 litres in fiscal 1980-81.

Consumption of spirits dropped to 4,246,452 litres from 4,339,697 litres. Using the NBLC rounded-off population figure of 700,000, that means a per capita rate of 6.06 litres and a decline of 2.73%.

The beer total declined to 52,287,263 litres from 55,055,382 litres, for a per capita consumption of 74.60 litres, a reduction of 5.6%.

Whether more moderate drinking, with food as an integral part of an evening out, or more cosmopolitan tastes are involved is not clear, but the consumption of wine increased to a total of 2,787,712 litres, compared with 2,579,724 litres in the previous year. The per capita rate of consumption increased to 3.98 litres from 3.70 litres, a gain of 7.57%.

But prices at government stores and in licensed premises took their toll, with gross income from the sale of liquor climbing to $156,085,499 from $137,801,210 — an advance of 13.26%. The NBLC net income was up by 7.54%, to $51,896,559 from $48,258,143 in 1980-81.

Beer remained the most popular beverage, accounting for 53.5% of the gross income from liquor. Spirits provided 37.8% of the total, wines 8.7%. For spirits, the share of the gross income was down from 39.3% in 1980-81.

In dollar terms, at $83,460,584 beer increased 16.1%, wine was also up 16.1% at $13,668,381, while spirits advanced only 8.9% to $58,956,534.

Nearly 39% of alcohol sales took place within the boundaries of the three major cities, Saint John, Moncton, and Fredericton. Saint John led with total sales of $28,023,677.

The university city of Fredericton again laid claim to the government liquor store with the greatest sales. The Fredericton Mall outlet took in $6,979,574.

New Books by RON HALL

Drug Problems, People Problems:

Causes, Treatment, and Prevention

. . . by Jara A. Krivanek

This book was prepared for individuals who deal directly with people who use and misuse drugs. The approach is multidisciplinary because of the nature of the problem, but it is not intended to give expertise in any of the many relevant areas. Nor is any attempt made to provide a compendium of the drugs subject to misuse or of the strategies that might be used in the treatment or prevention. Rather, the aim has been to demystify the technical aspects and present the broadest possible range of facts, attitudes, and opinions on the drug problem and solutions to it. The opening chapter deals with basic issues concerning drugs and their use. Pharmacology, physiological and behavioral effects, and symptoms of alcohol misuse are discussed in the next section. Epidemiology of drug use and drug-related problems in Australia forms the third chapter. Other topics discussed include: bases of addiction, approaches to treatment, individual and group counselling, drug and alcohol services in Australia, preventive strategies, and contacts for drug and alcohol information.

(Allen and Unwin, Inc, 9 Winchester Terrace, Winchester, MA 01890, 1982. 216 p. $10.95. LC 82-71783.)

Chemical Dependency and Violence:

Working with Dually Affected Families

. . . by Janet M. Wright

This cross-training program manual for counsellors and advocates working in the fields of family violence and substance abuse is divided into two main sections. The part on woman abuse is to be used by counsellors and advocates in the family violence field to train substance abuse counsellors, and the other section is for chemical dependency counsellors to train family violence counsellors/advocates. These sections provide information and training on intervention, identifying problems, working with family members, child abuse/neglect, incest, legal implications, and client resistence. Facilitation notes and 40 reproducible handouts, worksheets, and sample assessment forms accompany this 18-hour training model.

(Wisconsin Clearinghouse, 1954 E Washington Ave, Madison, WI 53704, 1982. 134 p. $11.50.)

Other books

Social Aspects of Benzodiazepine Prescribing Today — Ward, John. F. Hoffman-La Roche, Basel, 1980. Dependence; overconsumption; incidence of disturbances justifying the prescription of tranquillizers; prescription of psychotropic drugs; public health and social problems; alternatives. Refs. 22 p. F. Hoffmann-La Roche, CH-4002, Basel, Switzerland.

Me, Mother of a Drug Addict — Leroyer, Micheline. Christian Journals, Ottawa, 1981. Narrative of a mother's seven-year experience with her son's drug abuse problem; therapeutic community at Levant in Switzerland. 106 p. Christian Journals, 760 Somerset St W, Ottawa, ON K1R 6P9. $6.95. ISBN 0-904302-65-2.

Entering Stargate: An Operating Manual for Prevention Programming on Spaceship Earth — Orr, Bonnie. Texas Commission on Alcoholism, Austin, 1980. Information on alcohol-specific education strategies; prevention issues; monitoring and evaluating; intervening with children from alcoholic homes; resources and other materials. 99 p. Texas Commission on Alcoholism, 8th Floor, Sam Houston State Office Building, 201 E 14th St, Austin, TX 78701. $4.50.

Benzodiazepines: A Review of Research Results 1980 — US Government Printing Office, Washington, 1980. NIDA Monograph No 33; biochemistry; anatomical aspects; self-administration in animals and humans; dependence studies; clinical use patterns; carryover effectiveness, rebound insomnia, and performance effects. 101 p. US Government Printing Office, Washington, DC 20402. $4.75. S/N 017-024-01108-8.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Ontario Psychiatric Volunteer Conference — Apr 19, Toronto, Ontario. Information: Rena Scheffer, Community Mental Health Consultant, Canadian Mental Health Association, 8 Pailton Cres, Toronto, ON M4S 2H8.

11th Annual Conference on the Family — Apr 21-22, Toronto, Ontario. Information: Anna Cavaliere, Program Coordinator, Centre For Continuing Education, York University, 4700 Keele St, Downsview, ON M3J 2R6.

25th Annual Scientific Assembly of the College of Family Physicians of Canada — Apr 24-27, Toronto, Ontario. Information: George Ackehurst, Director of Communications, The College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

Canadian Addictions Foundation Annual Meeting — May 2-4, Medicine Hat, Alberta. Information: Jim Edwards, Executive Director, Canadian Addictions Foundation, Pacific Plaza, Box 702, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

Canadian Guidance and Counselling Association 9th Biennial Conference — May 31-June 3, Fredericton, New Brunswick. Information: Richard Harvey, Conference Chairman, CGCA '83, PO Box 1983, Station A, Fredericton, NB E3B 5G4.

3rd Annual Summer School on Addictions — June 19-24, Charlottetown, Prince Edward Island. Information: The department of Extension and Summer Sessions, University of Prince Edward Island, Charlottetown, PEI C1A 4P3.

24th Annual Institute on Addiction Studies — July 17-22, Hamilton, Ontario. Information: Alcohol and Drug Concerns Incorporated, 15 Gervais Dr, Ste 603, Don Mills, ON M3C 1Y8.

International Doctors in Alcoholics Anonymous Annual Meeting —Aug 4-7, Vancouver, British Columbia. Information: Lewis Reed, MD, IDAA Secretary, 1950 Volney Rd, Youngstown, Ohio 44511.

Royal College of Physicians and Surgeons Annual Meeting — Sept 19-22, Calgary, Alberta. Information: Robert A. Davis, Associate Director, Office of Fellowship Affairs, Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

1984 Canadian Addictions Foundation Regional Conference — Apr 29-May 3, 1984, Halifax, Nova Scotia. Information: Canadian Addictions Foundation, Pacific Plaza, Box 702, 10909 Jasper Ave, Edmonton, Alberta T5J 3M9.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th Floor, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

Impact: Adolescent Chemical Dependency, A School and Community Approach — Apr 11-15, Los Angeles, California, May 2-6, Orange, California. Information: Tim Allen, CompCare LifeStyle Center, 2101 E 4th St, Ste #185, Santa Ana, CA 92705.

4th Regional Conference on Substance Abuse — 1984 Alternatives: Treatment and Funding — Apr 13-15, Cincinnati, Ohio. Information: Ann Blankenhorn — C & E, Central Community Health Board, 532 Maxwell Ave, Cincinnati, OH 45219.

Current Drug Use — Apr 13-May 11, Orange, California. Information: CareUnit Hospital of Orange, 401 S Tustin Ave, Orange, CA 92666.

Alcohol and Drug Problems Association Eastern Regional Conference — Apr 17-20, Hartford, Connecticut. Information: Eric Scharf, ADPA, 1101 15th St, NW, Washington, DC 20005.

National Conference on "Working Women and Substance Abuse" — Apr 28-29, Washington, DC. Information: Lee Levin, Administrative Director, 15 Union Square, New York, NY 10003.

American Psychiatric Association, Annual meeting — April 30-May 6, New York, NY. Information: Dr Mel Sabshin, 1700 18th St NW, Washington, DC 20009.

Alaska's 9th Annual School on Addiction Studies — May 2-6, Anchorage, Alaska. Information: Center for Alcohol and Addiction Studies, University of Alaska, 3211 Providence Dr, Anchorage, AK 99508.

Conference on Alcoholism Treatment and Culture: Comparative Perspectives from Europe and America — May 5-7, Farmington, Connecticut. Information: Margie Meadows, department of psychiatry, University of Connecticut Health Center, Farmington, CT 06032.

1st Annual Substance Abuse Conference: Treatment Issues — May 8-10, Casper, Wyoming. Information: Carol Day, Division of Community Programs, department of Health and Social Services, Hathaway Building, Rm 363, Cheyenne, WY 82002.

Computers and Quality Assurance — May 9-11, East Brunswick, New Jersey. Information: General Information, PO Box H, East Brunswick, NJ 08816-0257.

Management Skills for Occupational Health Nurses — May 10-12, Boston, Massachusetts. Information: Office of Continuing Education, Harvard School of Public Health, 677 Huntington Ave, Boston, MA 02115.

TEC (Take Effective Control) — May 11-18, Milwaukee, Wisconsin. Information: Candee Brandis, training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Biotechnology: Procedures and Applications — May 16-18, East Brunswick, New Jersey. Information: General Information, PO Box H, East Brunswick, NJ 08816-0257.

15th Annual Southwestern School for Behavioral Health Studies — May 16-20, Tucson, Arizona. Information: Pat Walker, Program Director, Southwestern School for Behavioral Health Studies, 2222 N Craycroft, Ste 1-F, Tucson, AZ 85712.

3rd Annual National Conference for Nurse Educators on Current Issues in Alcohol and Drug Abuse: Research, Education, and Clinical Practice — May 18-20, Washington, DC. Information: Geral Dene M. Burdman, PhD, Alcohol and Drug Abuse Nursing, SC-78, School of Nursing, University of Washington, Seattle, WA 98195.

5th Annual School on Alcoholism for Physicians and Related Health Professionals — May 19-21, New York, NY. Information: NYU Post-Graduate Medical School, 550 First Ave, New York, NY 10016.

Scientific and Regulatory Aspects of Bioavailability of Drugs and Pharmacokinetics — May 23-25, East Brunswick, New Jersey. Information: General Information, PO Box H, East Brunswick, NJ 08816-0257.

Drinking and Driving Symposium — May 31, Detroit, Michigan. Information: James Schaefer, Director, Office of Alcohol and Other Drug Abuse Programming, Rm 360, 2610 University Ave, St Paul, Minnesota 55114.

Introduction to Pharmacology — June 1-3, East Brunswick, New Jersey. Information: General Information, PO Box H, East Brunswick, NJ 08816-0257.

Pulling Together — The Many Issues of Ethical Principles — June 5-7, Traverse City, Michigan. Information: Sally Myers, MAAA, 29563 Northwestern Hwy, Ste 7, Bldg F, Southfield, MI 48034.

International Summer School on Counselling the Family of the Chemically Dependent — June 6-9, Moorhead, Minnesota. Information: Debby Thornton, CD School secretary, department of social work, Moorhead State University, Moorhead, MN 56560.

4th Annual National Conference on Employee Assistance Programming — June 6-9, Kansas City, Kansas. Information: The EAP Conference Center, Bethany Medical Center, 51 North 12th St, Kansas City, KS 66102.

Alcohol/Drug Dependency and Mental Illness — June 7-8, Oct 11-12, Center City, Minnesota. Information: Marilyn Brissett, Continuing Education department, Hazelden Foundation, Center City, MN 55012.

5th Annual Summer Institute — Alcohol and Relations: Our Chemical, Ourselves, Our Kids, Our Families, Our Jobs, and Our Intimate Others — June 10-11, Milwaukee, Wisconsin. Information: Candee Brandis, training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

10th Annual South Carolina School of Alcohol and Drug Studies — June 12-17, Rock Hill, South Carolina. Information: Julie Trent, SCCADA, 3700 Forest Dr, Columbia, SC 29204.

Fostering Chemical Health: A Workshop For Youth Leaders — June 15-16, Center City, Minnesota. Information: Marilyn Brissett, continuing education department, Hazelden Foundation, Center City, MN 55012.

University of Utah School on Alcoholism and Other Drug Dependencies — June 19-24, Salt Lake City, Utah. Information: University of Utah School on Alcoholism and Other Drug Dependencies, PO Box 2604, Salt Lake City, UT 84110.

Alcoholism in the Workplace — June 21-23, Boston, Massachusetts. Information: Office of Continuing Education, Harvard School of Public Health, 677 Huntington Ave, Boston, MA 02115.

The Role of the Nurse in Chemical Dependency Treatment — June 27-July 1, Center City, Minnesota. Information: Marilyn Brissett, continuing education department, Hazelden Foundation, Center City, MN 55012.

Pharmacology for the Nurse — June 27-28, Center City, Minnesota. Information: Marilyn Brissett, continuing education department, Hazelden Foundation, Center City, MN 55012.

Children of Alcohol/Drug-Dependent Parents — July 11-12, Indianapolis, Indiana. Information: Kay Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Sexuality, Intimacy, and Alcohol/Drug Dependence — July 25-26, Indianapolis, Indiana. Information: Kay Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

12th Annual Southern Oregon Institute of Alcohol Studies — July 31-Aug 5, Salem, Oregon. Information: Ruthanne Lidman, SOIAS, 4540 Liberty Rd S, Salem OR 97302.

National Association of Alcoholism and Drug Abuse Counsellors (NAADAC) Conference — Aug 7-10, Houston, Texas. Information: David W. Oughton, National Association of Alcoholism and Drug Abuse Counsellors, 951 South George Mason Dr, Ste 204, Arlington, Virginia 22204.

Alcohol and Drug Problems Association of North America 34th Annual Meeting — Aug 28-Sept 1, Washington, DC. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

Training Program for Alcoholism Counselling — Sept 10, 1983-Jan 21, 1984, Jan 31, 1984-June 2, 1984, Amityville, New York. Information: The Institute of Alcohol Studies at South Oaks, PO Box 426, Amityville, NY 11701.

Drug and Alcohol Issues Symposium — Sept 14-16, Dayton, Ohio. Information: Thomas Prugh, WORAC, 379 W First St, Ste 300, Dayton, OH 45402.

Group Counselling Skills for Alcohol/Drug Clients — Sept 26-28, Indianapolis, Indiana. Information: Kay Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Basic Drug Information for Alcohol/Drug Counsellors — Oct 10, Indianapolis, Indiana. Information: Kay Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Intervention-Counselling Techniques — Nov 7-9, Indianapolis, Indiana. Information: Kay Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

American Society of Criminology 35th Annual Meeting — Nov 9-12, Denver, Colorado. Information: Joseph E. Scott, department of sociology, Ohio State University, Columbus, Ohio 43210.

Abroad

7th World Congress on Acupuncture — May 2-7, Biarritz, France. Information: World Union of Acupuncture Scientists and Societies, 4, Avenue Marceau, 75008 Paris, France.

2nd European Symposium of Acupuncture — June 3-5, Stockholm, Sweden. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncutre, Colombo South General Hospital, Kalubowila, Sri Lanka.

29th International Institute on the Prevention and Treatment of Alcoholism — June 27-July 2, Zagreb, Yugoslavia. Information: Archer Tongue, ICAA, Case postale 140, 1001 Lausanne, Switzerland.

9th International Conference of the International Association for Accident and Traffic Medicine — July 10-15, Mexico. Information: Dr R. Andreasson, IAATM, PO Box 10043, 5-100 55 Stockholm 10, Sweden.

8th Institute on Drugs, Crime, and Justice in England and America — July 11-15, London, England. Information: Institute on Drugs, Crime and Justice, School of Justice, The American University, Washington, DC 20016.

7th World Congress of Psychiatry — July 11-16, Vienna, Austria. Information: Congress Team International, PO Box 9, A-1095 Vienna.

Australian Medical Society on Alcohol and Drug Related Problems 3rd Annual Conference — July 31-Aug 7, Cairns, North Queensland, Australia. Information: Conference Organizers, PO Box 155, Civic Square, ACT, 2608, Australia.

Middle Eastern Summer Institute on Drug Use (MESIDU): Techniques, Strategies, Concepts, and Information: Stan Einstein (PhD), Director, MESIDU, 113/41 East Talpiot, Jerusalem, Israel.

International Conference on Alcoholism — Sept 26-30, Reykjavik, Iceland. Information: International Council on Alcohol and Addictions, Case postale 140, 1001 Lausanne, Switzerland.

13th International Institute on the Prevention and Treatment of Drug Dependence — Oct 10-14, Oslo, Norway. Information: ICAA, Case postale 140, 1001 Lausanne, Switzerland.

8th World Congress of Acupuncture — Oct 12-16, Seoul, Korea. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hosital, Kalubowila, Sri Lanka.

9th International Conference on Alcohol, Drugs and Traffic Safety — Nov 13-18, San Juan, Puerto Rico. Information: T-83 Secretariat, GPO Box 5067, Medical Sciences Campus, San Juan, Puerto Rico 00936.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

2nd International Congress on Drugs and Alcohol — Dec 18-22, Tel Aviv, Israel. Information: Judge Amnon Carmi, Chairman, Organizing Committee, 2nd International Congress on Drugs and Alcohol, PO Box 394, Tel Aviv 61003, Israel.

4th World Congress of Alternative Medicine — July 13-15, 1984, Amsterdam, Netherlands. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

Teens & drugs: parents grapple with prevention

By Eileen Morrow

TORONTO — As the wave of grassroots anti-drug groups spills across North America, drug professionals view with mixed feelings the philosophies, tactics, and results of the popular parents' movement.

Is it the missing link in drug abuse prevention? Is it a passing fad? Or is it the sincere expression of frightened parents who feel helpless against what they see as an evil force in their children's lives — a force they feel drug professionals have been powerless to exorcise.

In the past five years, parents have banded together in more than 3,000 groups. They encompass a range of child-rearing philosophies: from local Parent-Teacher Association education programs, to groups like the popular ToughLove self-help groups where teens are made to take the consequences of their misbehaviors (including drug use) even if it means being kicked out of the house or turned over to police.

Growing interest in Canada is witnessed by the formation of ToughLove and similar groups across the country, as well as the ushering in of a parent group in Toronto committed exclusively to eradicating drug use by teens. The new group, Parents Against Drugs (PAD), was officially launched recently at a meeting of 300 parents. Since then, PAD has received calls from parents across Ontario wanting to know how they can start their own groups.

Parents in the United States began their movement in the late 1970s as a reaction to what they saw as an epidemic of teenage drug use. But in Canada, say professionals, there is no epidemic.

Michael Jacobs, psychologist with Ontario's Addiction Research Foundation (ARF): "A large percentage of kids in Canada haven't had any contact with drugs and a fair percentage of those who've tried it, have tried it once or twice and don't need to try it again. It's not the sweeping problem some parents think."

Norman Panzica, a drug counselling specialist with a loose affiliation to PAD, agrees teen drug use in Canada is not the problem it is in the US.

"The truth is that most kids don't do drugs," he says. "The bottom line is just that simple."

But Michael and Michelle Noar, one of two couples who started the Toronto group, see teen drug use as a major problem that many school and drug professionals are reluctant to face.

"The problem is horrendous," says Mr Noar. And his wife adds: "We're going to end up with a whole generation of psychologically impaired people by the time they've reached their middle twenties if we don't stop it."

Because anti-drug groups tend to see drug use as out of control, many of them are willing to support a variety of tactics aimed at reversing the trend, ranging from education and health programs, through treatment and intervention, to tougher court sentences for teen drug offenders.

Drug professionals worry that groups that concentrate on scare education packages and punitive anti-drug measures may do more harm than good. And they caution parents against what they see as authoritarian responses to teen drug use.

Dr Jacobs: "Where groups take a very dramatic or radical view toward eradicating marijuana use, they may end up unwittingly encouraging some young people to use marijuana more frequently and to flaunt it, rebelling in a way that adolescents have always done."

While counsellors agree teens need consistent ground rules and direction from parents, they say discipline and supervision can go too far.

Mr Panzica says teens should be trusted until there is evidence of wrong-doing, and parents should be careful not to over-react to teen drug problems.

"What we do *not* need are vigilantes," he says. "We do not need cars parked in school yards with binoculars. I don't believe in snooping or reading diaries, or monitoring phone calls, or censoring mail."

Keith Manatt Schuchard, PhD, co-founder of Parent Resources Institute for Drug Education (PRIDE), one of the first anti-drug parents' groups in the US, defends parents who advocate room and locker searches and rejects critics who have labelled the groups "right-wing."

"It's something every parent wishes they didn't have to do," says the author (under the name Marsha Manatt) of *Parents, Peers and Pot*. "But, if you have a child on drugs and you don't search their room, are you responsible for the outcome? What you're saying to the child is you have the right to lie, cheat, break the law, because of your privacy. You have the right to risk your life.

"In this country (the US), there's been a tremendous intimidation through libertarian rights activists of the protection of people who are indeed breaking the law." Dr Schuchard says writing off the parents' movement as reactionary would not only be unfair, but untrue, and she cautions Canadian groups not to allow critics to label them. In reality, she adds, grassroots parents groups are an extension of the idealism of the 1960s without the drugs.

"It is a reaffirmation of the ideals of the civil rights movement in the US, ideals of human worth and of increasing opportunities for people to make something of their lives, not just to be blown away in the privacy of their chemicals."

Dr Schuchard advocates not only strong parental ground rules in the home, but also tough school and community policies.

"We feel the most effective alliance is between a strong parent support group for the schools and then a very clear, tough policy within the schools. And we do mean tough. We mean an alliance between the police, schools, medical profession, and parents," she says.

As a model example, she describes one US high school where police are called if any evidence of drugs or alcohol is found, regardless of its degree. Parents support

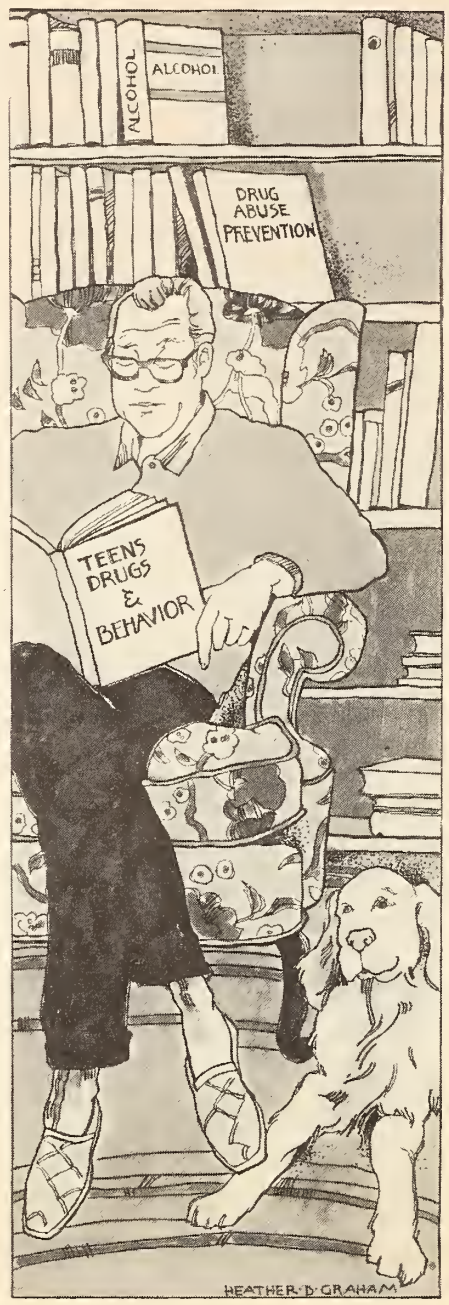
the school decision, and the local court officials then require treatment and counselling for child and family depending on the severity of the offence. (**The Journa**l, Sept, 1982)

Dr Schuchard: "They rarely have to call police because the kids now know they will be called on every occasion, and this has been a tremendous deterrent."

For many parents and drug professionals, arguments about how to stop teen drug use boil down to a fundamental disagreement about the causes of adolescent fascination with drugs and alcohol in the first place.

Parent groups are almost universally convinced that teens use drugs primarily because their peers do, and because big-money drug producers are luring average kids into an ever-increasing drug culture.

Carolyn Burns is parent coordinator of the National Federation of Parents for Drug-Free Youth, an umbrella organization for parents' groups across the US.



"What we see as the biggest problem facing our teenagers today is the kind of pressure that they have to do these drugs and the availability of drugs that exists today. I'm told by kids that you can get drugs within five minutes in any school in the US."

Michael Noar of the Toronto group concurs: "These are good kids. One way or the other they have been misled somewhere, and to try and get out of it is difficult because of the peer pressure."

The groups do not differentiate between teens who use marijuana and alcohol occasionally or who experiment with drugs, and teens who use drugs regularly and heavily.

Ms Burns: "We take a stand on no responsible use by adolescents. In other words, there is no such thing as responsible use of either alcohol or drugs by adolescents because both are illegal and unhealthy."

Drug counsellors, on the other hand, are apprehensive about programs that lump occasional and regular users together. While they agree teens may use drugs occasionally as a result of peer pressure, they suggest heavy and regular users have far more serious reasons for their drug consumption. And they fear parents who paint peer pressure as the main villain may be missing some urgent emotional problems in their families.

"People who assume that kids who are heavy users don't have personal problems — don't come from homes where emotional difficulties and communication difficulties exist — are kidding themselves," says Dr Jacobs.

And, he adds, many teens today who use drugs regularly are trying to escape a sense of hopelessness about their future in the face of serious societal pressures.

"Drug use is a symptom of that, not the disease. And parents who try to eradicate the symptom have done a very superficial job. Drug use reflects society, not the other way around."

Dr Jacobs suggests the first priority of parents' groups should be to focus on changing the way family members relate to one another and on positive fundamental values, rather than on eradication of drugs and drug paraphernalia from schools and communities.

Whatever the cause of teen drug use, parents say their methods are effecting positive changes in their homes and schools. (And, in fact, a recent nationwide survey from the National Institute on Drug Abuse in the US shows daily marijuana use among high school seniors declined for the fourth consecutive year from a high of 10.7% in 1978 to 6.3% in 1982. See page 9).

Dr Schuchard says: "What we see coming back into our teenagers' social lives is a tremendous increase in morale, ideals, and expectations of themselves."

She says kids see the increased parental supervision and tough school rules as fair because they apply to all. And grateful, drug-free teens are now beginning to form, with parent help, their own anti-drug groups and activities.

"We find that once parents get organized, get themselves educated, and make clear what the ground rules are going to be, we find the kids coming along with it and joining in with student groups, peer counselling — wanting to be part of the solution and wanting to work with younger kids," says Dr Schuchard.

Despite some concerns about the parent movement, many professionals also see the trend as a potentially positive addition to the war against drugs.

Mr Panzica strongly supports the groups and says parents have long been the weak link in the chain of drug use prevention. "One of the great advantages they can give us is they could be a mechanism on two counts: one is that those who have had the problem may very well have younger kids. The other is that present-day parents, I would hope, are more interested in parenting than, say, 18 years ago. So that a group like that could sift through huge tons of material and find things that they, as practising parents, think would be useful to themselves and to others."

In the enforcement and treatment areas, Mr Panzica sees the parent movement as a catalyst for better school drug policies and for more and better treatment facilities.

Kathleen Michael, a family therapist and community consultant with the ARF, says the support parents give each other in self-help groups may lead to better family relationships whatever anti-drug tactics the group may embrace.

"I think they have strength in numbers and get emotional feedback from their adult peers, so they indirectly change their behavior. They indirectly have more communication and see what's going on with their teens as opposed to being emotionally involved to the degree that they can't think straight."

While she disagrees with parent groups that lean toward punitive and scare tactics to stop drug use, Ms Michael says groups that use positive methods can be a "definite plus" in drug use prevention.

"If they have groups for parents to learn about drugs *and* behavior, and positive alternatives, they can sharpen their skills as parents. It doesn't mean they're not good parents. It just means that this is a new problem they didn't have to cope with when they were kids, so how do we cope with it?"

Along with efforts to set up student self-help groups, Ms Michael says the movement needs to put a stronger emphasis on individual teen needs, and greater involvement by fathers in grassroots parents' groups. She says parents' groups she has worked with have been almost exclusively female.

Dr Jacobs says the most positive thing about grassroots groups is their ability to galvanize the community around issues that concern them. And, he says, the anti-drug parents' groups could use this bonding skill positively to raise public awareness about drugs, propel school authorities into action, and let kids know how adults feel about their drug use.

"There are some very good things that can come from these kinds of groups," he says. "I just hope that emotion plays a secondary role to logic and reason. If groups get too emotional, they'll weaken their effectiveness."

THE BACK PAGE

Natives seeking liquor warning labels

By Maureen Brosnahan

WINNIPEG — The federal government will be asked to force producers of all wine and spirits sold in Canada to carry warnings for pregnant women that drinking will endanger the health of their unborn children.

The proposal was made at a national conference on fetal alcohol syndrome (FAS) here by Marilyn Van Bibber, a member of the National Native Advisory Council on Alcohol and Drug Abuse.

Ms Van Bibber, head of research for the council and director of health and social development for the Yukon Council of Indians, said the request will be sent to federal Health Minister Monique Begin and Consumer Affairs Minister André Oulette following the council's next meeting in June.

Ms Van Bibber said native people as a race are being weakened by alcohol and that the quality of Indian life "is now seriously threatened by the mutilation of our babies."

She called on the government to "take immediate steps toward requiring the producers and distributors of all wines and spirits to warn that consumption during pregnancy is harmful to the unborn child."

Spokesmen for the provincial liquor commissions in Manitoba and Saskatchewan said such a recommendation would have to be enforced by the federal government. "The costs would just be horrendous" for the provincial body, said Murray Wilkie, vice-chairman of the Saskatchewan Liquor Board.

Mr Wilkie said he expected the producers and distillers would "object strenuously" to such a proposal because "not enough is known" about the relation between alcohol and fetal development.

Don Lucier, a spokesman for the Manitoba Liquor Commission, said it's the first time he's heard such a suggestion put to the government.

Such labels would have to be proposed by the federal health department and enforced by consumer affairs, said Sheila McDermott of the labelling division of the federal consumer and corporate affairs department in Ottawa. Ms McDermott said a similar move was once proposed in the United States. (**The Journal**, Jan, 1979). "I've heard of it but I don't think anything has actually been done," she said.

Van Bibber: protecting our babies

Ms Van Bibber told **The Journal** the warning should take the same form as the one now found on tobacco products sold in Canada. "It would be on every bottle."

Ms Van Bibber said she believes such a warning would have an effect on the drinking habits of pregnant women.

Ms Van Bibber said the syndrome is a real threat to native Canadians, much more so than the loss of aboriginal rights.that is being debated by native leaders now across Canada.

"The true potential of Indian people may be in jeopardy," she said.

"We cannot over-emphasize the cost of protecting our babies," she said, adding that preventive programs must be initiated from within the native communities (**The Journal**, Feb, 1979).

Earl Duncan, an Indian alcoholism counsellor with the Alcoholism Foundation of Manitoba, said FAS "is a very damaging thing in terms of native people.

"Indian people think very highly of their children," he said, adding that an Indian mother suffers a great deal of guilt when told she is the cause of her child's condition.

This can lead to other problems, Mr Duncan said, and the FAS child can become the scapegoat in the family, especially with the father. "Every time he looks at the child, the wife could get the abuse.

"It s not social problems but social pressures that make people drink," he added.

The national conference on FAS was sponsored by the federal government's Native Alcohol and Drug Abuse Program.

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The Journal

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CIDA funding health plan in Thai opium villages

TORONTO — The Canadian International Development Agency (CIDA) has approved $244,706 for a four-year project to establish basic health care services for the opium-producing villagers of northwest Thailand.

The area is part of the Golden Triangle where Thailand, Burma, and Laos meet. Opium from the mountain region, particularly now from Burma, accounts for a significant proportion of the world's heroin supply.

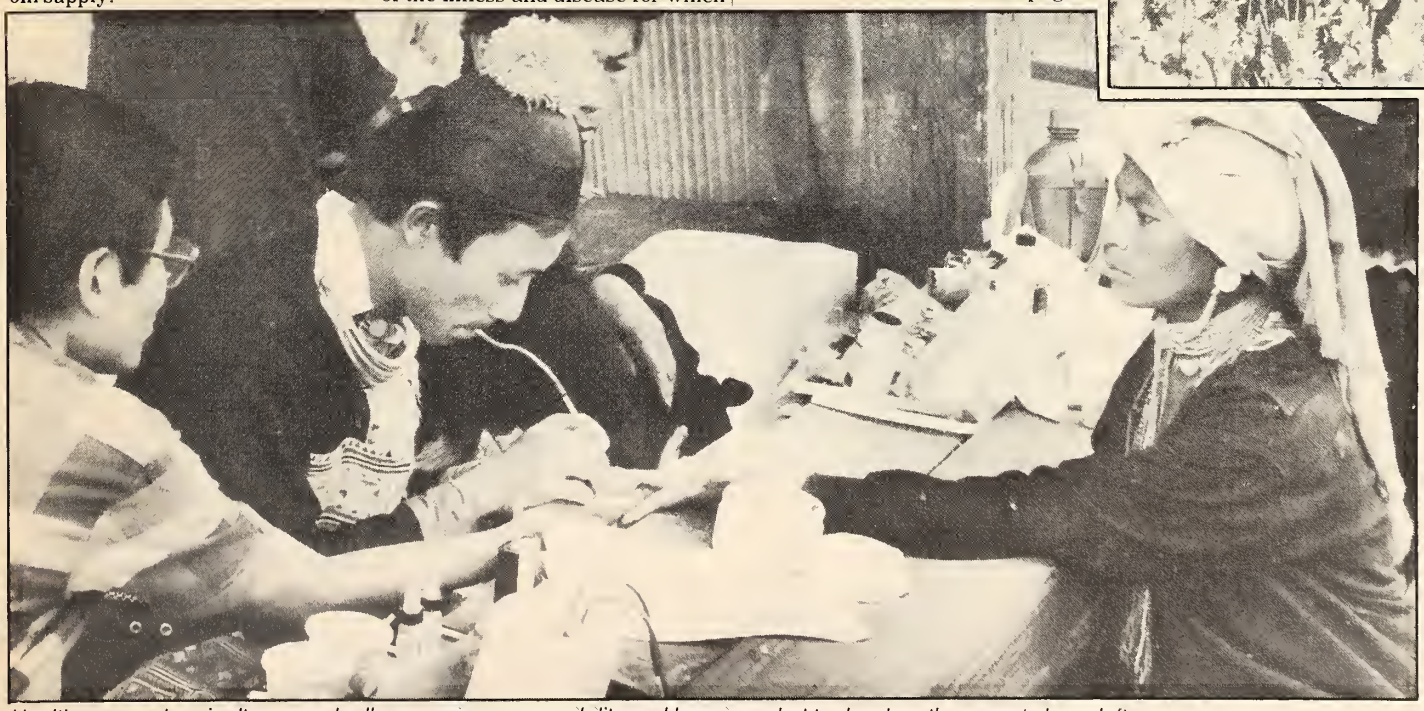
H. David Archibald, who will monitor the project, says it is a comprehensive program to train villagers in preventive health care and agricultural methods in order to raise economic and nutrition standards and reduce dependence on opium. Opium is not only the sole cash crop in the villages but it is also the only medicine available.

The village health care workers will be trained gradually to assume responsibility for treatment of the illness and disease for which villagers traditionally, and almost exclusively, have used opium.

Mr Archibald, a consultant to the Addiction Research Foundation (ARF) and the World Health Organization (WHO), said: "The very basic philosophy is to help the villagers help themselves and to establish programs the villagers themselves can duplicate once we've left."

The program is based on and will utilize experience gained on simi-

(See — Thai — page 6)



Health care and agriculture: gradually assuming responsibility and learning what to do when the experts have left

Lung cancer in women on rapid increase

By Mark Kearney

TORONTO — Deaths from cancer of the respiratory system — mostly lung cancer — among Ontario women have increased dramatically since 1975.

And the mortality rate may continue rising for the next 20 to 30 years because of the increasing number of young women smoking, says an epidemiologist with the Ontario Cancer Treatment and Research Foundation (OCTRF).

Loraine Marrett, PhD, says deaths from lung cancer are still higher among men, but in recent years women have been catching up. The death rate among men, which rose dramatically from 1931 to 1980, seems to be tapering off while still rapidly increasing for women, she says.

The mortality rate among women in 1931 to 1935 from cancer of the respiratory system, excluding the larynx, was 2.14 deaths per 100,000 population per year. The rate increased to 9.02 deaths in 1971 to 1975 and to 12.23 deaths in 1976 to 1980.

Statistics for the first year of the next five-year period are available, but Dr Marrett cautions against comparing one year to the five-year totals in the study. The mortality rate in 1981 was 14.85 deaths.

The rate for men in 1931 to 1935 was 3.93 deaths per 100,000 population and had risen to 46.63 for the 1971 to 1975 period. The figure rose more slowly in 1976 to 1980 to 51.22 deaths and the 1981 total of 52.33 deaths shows the rate has levelled off, she says.

Dr Marrett says that while lung cancer is increasing, the total cancer rates for women have declined steadily for the past 50 years. Cigarette smoking is the main cause of the lung cancer increase although air pollution may have some effect, she says,

She told **The Journal** the figures indicate more anti-smoking campaigns, especially aimed at young women, are needed. With so many young women smoking now, it could be another 20 to 30 years before the effects on the mortality rates are known, Dr Marrett adds.

A recent survey by Health and Welfare Canada (**The Journal**, April) reported the percentage of teenage girls who smoke had increased to 23% in 1981 from 20% in 1966. Teenage boys regularly smoking declined by 35% in the same 15 years to about 23%.

Dr Marrett and E. Aileen Clarke, MB, who heads the OCTRF's division of statistics and epidemiology, studied trends in cancer mortality in Ontario from 1931 to 1980 and presented their findings at the University of Toronto's second annual research day.

INSIDE

NEWS

Briefly. . .

Cocktail calculator

TOLEDO — People who want to drink but not end up in the clink are buying "cocktail calculators" whose warning light goes on when the drinker is "lit up." The pocket breath tester on sale in April to American Express cardholders in the United States is activated by a blood alcohol content of 0.05% and higher. The legal limit in most states is 0.10%. So now, the company that says "don't leave home without it" can also say "don't leave the bar without it."

Chugging along

INUVIK, NWT — It's not only the drinkers who do the chugging at the Finto Motor Inn here. Drinks are delivered to customers on a model train that chugs around the room. Even when it is not delivering drinks, the train is unusual; it's the only working railway in Canada north of the Arctic Circle.

Recycled cigarettes

OTTAWA — Cigarette butts thrown away in Kampuchean cities are being recycled and sold as "second-hand cigarettes" in rural communities, says an article in the Canadian Council on Smoking and Health newsletter. The recycling factories employ teams of young boys to collect the butts. The tobacco is washed, dried, and rolled into cigarettes for resale.

A penny a pint

BIRMINGHAM, ENG — Three alcoholism agencies here are suggesting an extra tax of a penny a pint of beer be levied to help alcoholics. But the idea isn't going down well with brewers, who argue they already spend £250,000 ($475,000 Cdn) a year funding research and education on alcohol abuse.

Smokers' holidays

LONDON — The practice in Britain of tobacco companies' using cigarette brand names to promote travel should be stopped, says the British Medical Association (BMA). Rothmans International is marketing holidays through Peter Stuyvesant Travel, Gallaher has launched Silk Cut Masterclass Holidays, and Phillip Morris is promoting Marlboro Adventure Holidays. The BMA claims the practice allows tobacco companies to plug cigarettes under the guise of advertising holidays, says a report in *Doctor*.

Pints and Puccini

MANCHESTER — Opera North is bringing its "Pints and Puccini" scheme to drinkers at working-men's clubs here to try to spread appreciation of opera and overcome its elitist image.

Cola controversy

LOS ANGELES — "Coke adds life," but it's also adding controversy to the 1984 Olympics here, where Coca-Cola is a sponsor. The International Olympic Committee's (IOC) medical commission may do drug testing in Europe instead of California unless caffeine, an ingredient in Coca-cola, and testosterone, are added to the list of drugs athletes can't use. The US is resisting even though an athlete would have to drink 20 litres of Coke a day to exceed the IOC's proposed allowable caffeine limit.

Cocaine infiltrating Canada as US scares off couriers

By Clive Thomas

TORONTO — The major offensive against illegal drugs in the United States is driving international traffickers into Canada, say the Royal Canadian Mounted Police (RCMP).

Cocaine, in particular, is being smuggled into Canada in greater quantities than ever before, with seizures of the drug at Toronto International Airport running 75% higher than one year ago.

While the increase is partly the result of the rising popularity of the drug among Canadians, the RCMP say much of the cocaine brought into Canada is destined for the US (**The Journal**, July, 1982).

Twelve regional anti-drug task forces have been set up across the US modelled on the successful South Florida Task Force (**The Journal**, Oct, April, 1982), established in early 1982 by President Ronald Reagan's administration.

"The pressure is sending the couriers further north," says Staff Sergeant Fred Foster, head of the 14-person RCMP drug squad at Toronto International Airport.

The squad seized drugs with an estimated street value of $3.1 million in the first three months of this year, more than two-thirds of it cocaine from Peru and Bolivia.

Prosecutions for importing and trafficking in cocaine and other drugs through the airport rose by 169% during the first quarter of 1983 compared to the same period in 1982.

"Just last week we seized two lbs (0.9 kg) from Lima, Peru. Two weeks before that it was eight lbs (3.6 kg)."

Sgt Foster says the cocaine is arriving in Toronto from the Caribbean and Mexico as well as the cocaine-producing countries of Peru, Bolivia, and Colombia. Couriers have been nabbed at Toronto on their way to various US cities, Montreal, and Italy.

But for every smuggler caught, at least three more walk through Canada customs undetected.

"We are picking up 20% to 25% on a good day," says Sgt Foster. "So you can see how much is still coming in."

The couriers aren't easy to spot.

Sgt Foster: "It's not the long-haired 'hippy' who's carrying this stuff. It could be a well-dressed businessman. And they carry the drugs in just about any way you can imagine — inside statues, in packs taped inside a girdle or to the thigh, in suitcases with false sides or bottom."

The RCMP squad works in cooperation with Canada customs officials, and Sgt Foster attributes most seizures to a 50-50 product of good intelligence outside the country and good detection methods at the airport.

The profits to be made from importing cocaine are luring many amateurs into the international trade, says Staff Sergeant Wayne Horrocks, head of the RCMP's cocaine unit in Toronto.

Body pack: anyone who travels

"Everybody who travels now can buy a lb of cocaine in Colombia for $10,000, come back to Toronto and sell the lot for $45,000," says Sgt Horrocks.

If it's cut into smaller parcels, the drug will bring an even bigger profit. Cocaine sells in Toronto for between $150 and $200 a gram. The drug sold on the street may be as little as 15% to 20% pure, mixed with sugar or even milk powder. A dealer might easily make a 2,000% profit.

"It's a hell of a big markup," says Sgt Horrocks.

The cocaine unit has grown from six staff in 1975 to 20 people today, but is not keeping pace with the growth of the cocaine trade.

"We're skimming the surface," Sgt Horrocks says. "We're a curtailing agency, keeping the dealers one step from wide-open trafficking. You knock off one trafficker and two more take his place."

Cocaine smuggling: a suitcase with a secret

Illicit drug trade seizures only 'scratch the surface'

OTTAWA — Canadian customs officers seized a record $73.3 million (street value) in illicit drugs in 1982, a 69% increase over the previous year.

Gerry Martyn, an official with the customs intelligence division here, says last year's seizures are "encouraging," but may only be scratching the surface of the drug trade.

The increase in customs seizures is partly a result of better training and education of customs officers about drugs, improved detection equipment, and superior intelligence information, he told **The Journal**.

Marijuana seized at ports, border points, and airports throughout Canada more than tripled the 1981 figure, he says. Customs officers seized 3.3 million grams of marijuana in 1982 compared to one million grams the previous year.

Seizures of solid hashish jumped to 822,000 grams in 1982 from 560,000 grams while liquid hashish seizures rose to 170,000 grams from 78,000 grams. Custom officers confiscated 21,500 grams of cocaine last year, about twice the previous year's total and seized 5,500 grams of heroin compared to 4,500 grams in 1981.

There were a total of 2,711 seizures last year, up from 1,952 in 1981. Most of the seizures took place in Toronto, Montreal, and Vancouver, the usual points of entry for international flights, Mr Martyn says.

OMA appeals to public

MDs tackle sidestream smoke

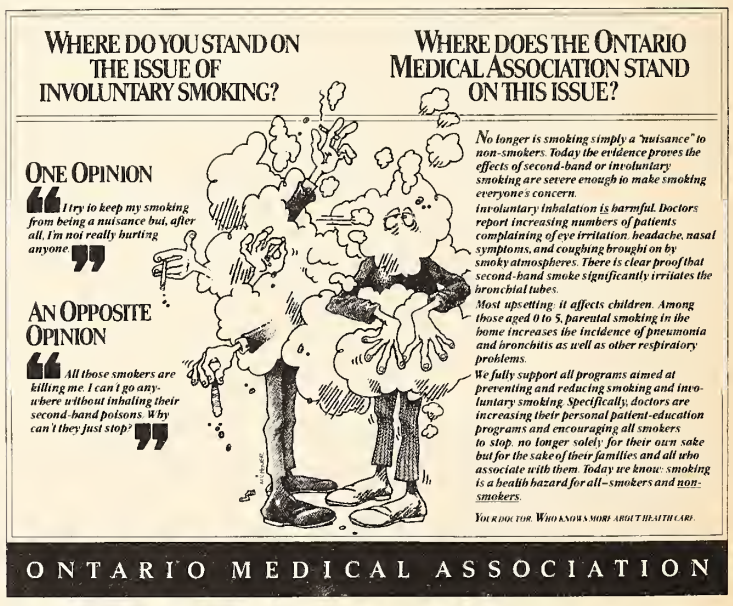
By Incor Jowat

TORONTO — Secondary or sidestream tobacco smoke is a proven health hazard, and it's time the public became concerned about the problem, says the Ontario Medical Association (OMA).

For this reason, the association recently sponsored a conference here with 19 representatives of Canadian and Ontario health, transportation, and service organizations to disseminate the results of recent studies and gather suggestions on how to deal with the situation.

Neville Lefcoe, a member of the OMA committee on public health, said information is "accumulating in hundreds of papers across the world that second-hand smoke is a health problem."

He said the OMA "recognizes a scientific basis for the view that there are short-term (acute) and long-term (chronic) health effects from exposure to second-hand tobacco smoke at home, in public buildings, the workplace, and transportation facilities, and that this exposure is a significant factor in a series of respiratory, cardiovascular, and pulmonary diseases."



An OMA newspaper advertisement on the subject produced as part of a campaign on health matters notes that sidestream smoke can also affect infants and young children. Dr Lefcoe said there is evidence unborn children are also affected.

He said there is also suggestive but not conclusive evidence linking sidestream tobacco smoke exposure with lung cancer in the long-term.

"How far we can go with voluntary restraints on the part of smokers, we're not certain," he said, admitting that the final solution is legislation, prohibiting smoking in public places.

While a certain percentage of the people are confirmed, even addicted smokers, Dr Lefcoe said, and "the social climate in this country has been that smokers have rights," the threat of legislation is very real.

Dr Lefcoe sees the solution involving fewer people smoking, the smokers being more aware and considerate, and "more and more industries, governments, and institutions providing separate, and I mean separate, areas for smokers."

NEWS

Low birthweight babies won't 'catch up'

Drink / smoke combo significant risk to fetus

By Harvey McConnell

LONDON — A woman who is a moderate social drinker when she conceives runs a slightly higher risk of delivering a lightweight infant than one who smokes but does not drink.

The most significant risk of delivering a lightweight infant, however, is run by women who both smoke and drink during the 10 weeks following conception, state findings by Jeremy Wright and colleagues in a long-term, multi-disciplinary study in the Charing Cross and West London Hospitals here.

Dr Wright said the data show no benefit from reduction of drinking in the later stages of pregnancy in either smokers or non-smokers.

He emphasized they found no cases of fetal alcohol syndrome (FAS) among the 903 Caucasian women who delivered a single infant following normal gestation even though some of the patients were very heavy drinkers.

By mid-1985, the team expects to report on another 3,000 such deliveries. Excluded from the study are women who miscarry or have complications, and those who deliver more than one infant. Non-Caucasian women are excluded from the drinking-smoking-birthweight aspect of the study because they tend to deliver infants who weigh less than the British norm.

Expanding on a report in *The Lancet* (see related story), Dr Wright told **The Journal**: "What we are trying to establish is whether there is a risk associated with normal social drinking, about 100 grams of alcohol a week, which is equivalent to 10 glasses of wine. It is a level of drinking I can certainly get through in a week with no difficulty at all.

"In terms of birthweight, there seems to be a risk. And the low-birthweight infant in general tends not to catch up in size," he said.

Drinking histories are obtained from all women attending the antenatal clinics, and they are asked to complete a questionnaire on their drinking the week before they first visited the clinic.

The women are classified as "heavy" drinkers (100 grams of alcohol a week), "moderate" (50 to 100 grams), "light" (less than 50 grams), and teetotal. No effort is made to alter drinking habits, but a government pamphlet is provided containing advice on diet, drinking, and smoking during pregnancy. The drink history is not available to the team of obstetricians looking after the patients.

Dr Wright said 10.9% of the infants were born with a birthweight below the average standard of measurement. Overall, 20% of the women were classed "heavy" drinkers and 26% smoked during pregnancy.

Only 26% of the non-smoking, "heavy" drinkers continued to drink heavily during pregnancy, and 17% produced a lightweight infant. Of the remaining 74% who reduced their drinking to 100 grams of alcohol a week or less, 10% produced a lightweight baby.

Among those who smoked and were "heavy" drinkers, 38% continued to drink heavily during pregnancy and 33% had a lightweight baby. Of the 62% of "heavy" drinkers who also smoked, and who reduced their alcohol consumption to less than 100 grams a week, 30% produced a lightweight infant.

Dr Wright said while they were not surprised to find the risk of delivering a lightweight infant higher among women who smoked and drank, they did not expect to find, as they did, "that the effects of drinking are slightly greater than the effects of smoking."

Few studies of the risks of smoking during pregnancy on the fetus have taken into account drinking patterns. Dr Wright said the obvious synergism between smoking and drinking "would explain why some smokers produce normal-size babies and some produce small babies."

However, Dr Wright said it is impossible to pinpoint exactly the time following conception when damage is done. "You would have to ask every woman who was six or more weeks pregnant: 'What were you drinking on Sunday a month ago, and on Monday and every other day?' This would be quite impossible on the scale of our study."

Alcohol is a toxin which goes straight across the placenta, and the damage appears to be done before the woman realizes she is pregnant. "Even if a woman stops drinking as soon as she has missed a period, she may have missed the boat in terms of the birthweight," he said.

No differences, except in birthweight, were found in infants born to women who drank.

Dr Wright: "We are not looking for very minor variances, which we might have missed, but only gross features. That is why we look at birthweight, which is an accurate and simple measurement."

Dr Wright, who has delivered more than 3,000 infants, said he has had only one case of a classic FAS infant. The baby was delivered by a woman who drank a bottle of vodka a day. "I think FAS exists, but it is a rare disease, and it is associated with pathologically heavy drinking."

Dr Wright said women should be advised to give up drinking and smoking over the time they are trying to conceive. And a woman who wants to drink should restrict it to one glass of wine a day."

Jan Waterson, a collaborator in the study said follow-up will investigate if any of the women have altered their post-natal drinking habits.

Dr Wright said that while drinking might carry a slightly higher risk of a low birthweight infant than smoking alone, smokers run a great risk of damaging their own health.

He said some questions about drinking and pregnancy remain unanswered. One is whether a woman who is a heavy drinker has harmed herself in such a way that even if she abstains before conceiving it would damage the fetus.

"In other words, would any abstention be a waste of time? It is possible, although I think it is unlikely. Our advice to women now is don't drink or smoke during the time you are trying to get pregnant."

Native FAS may be linked to genetics

By Maureen Brosnahan

WINNIPEG — The high incidence of fetal alcohol syndrome (FAS) among native people may be linked more to genetics than to the amount of alcohol consumed, says a Queen's University pediatrician and geneticist.

Patrick MacLeod of Queen's University, Kingston, Ont, told an FAS national conference here that a study of cases in Vancouver, where he began his research, showed more than 53% of children affected were of native ancestry even though they represent only 3% of the population.

He told **The Journal** it may not be the amount of alcohol consumed that is significant, but the way it works in the body. However, alcohol is definitely a risk to the unborn child. "It's frightening to me that after 20 weeks (in the womb) the (fetal) brain starts to develop. I can't believe that large amounts of alcohol in the brain are healthy."

Dr MacLeod said it could be that a difference in metabolism and the way enzymes work in the body influence the effect of alcohol on a native person. "Everybody assumes native people drink more. I'm not so sure that's true."

It could be that Indian people, because of their genetic makeup, face a "tremendously increased risk of alcoholism" in the same way that Jews are susceptible to Tay-Sachs disease and Blacks to sickle cell anemia, he said.

Lancet editorial

Women trying to conceive should avoid using alcohol

By Alan Massam

LONDON — Women who are planning to have a baby should give up drinking completely.

That's the advice in an editorial in the leading medical journal, *The Lancet*, following a study of 900 pregnancies at Charing Cross Hospital here.

It found that women who drink heavily — defined for the study as 10 drinks or more per week — were twice as likely to produce low-birth weight infants as women who drank half as much (see related story).

The Lancet says: "The findings are alarming. If validated, they indicate that considerable numbers of pregnant women may be putting their infants at risk, since heavy drinking, as defined for the purpose of the study, is not uncommon in women of child-bearing age.

"In England and Wales, 10% of women aged from 18 to 24 years and 30% of the 24 to 34 age group take more than three drinks daily.

"Especially worrying is the suggestion that the critical period is the early weeks after conception when many women may be unaware that they are pregnant.

"Until a threshold has been defined the best advice to women planning to become pregnant is to give up alcohol altogether or, alternatively, to limit themselves to five drinks a week."

The Lancet notes that babies of heavy-drinking mothers can suffer from growth failure, mental retardation, and head and face abnormalities with various associated physical defects.

It warns that fetal alcohol syndrome (FAS), is the third most common known cause of mental handicap and the most common preventable cause.

(The State of New York estimates a yearly cost of $155 million directly related to the birth of alcohol damaged children.)

Those most at risk, says *The Lancet*, are probably the offspring of women who drink "alcoholically" in pregnancy —from five to six drinks daily.

"Fetal alcohol syndrome is found in perhaps 30% of live infants produced from such pregnancies. But if infants exhibiting abnormal clinical features (falling short of the full FAS) are included, 50% to 70% of such pregnancies might have an abnormal outcome."

The Lancet concludes there has been growing concern in medical circles that moderate or even social drinking in pregnancy might be detrimental to the unborn child. Even women who regularly consumed one to two drinks daily were twice as likely as non-drinkers to have a spontaneous abortion. And women drinking as little as two drinks a week might be affected although such studies "have been criticized."

For information: Dr I. M. Murray-Lyon, Gastrointestinal Unit, Charing Cross Hospital, London W6, England.

New wave tech — or why Johnny can't cope

By Wayne Howell

The time: *the near future.*
The place: *a high school.*
Mr and Mrs Smith are ushered into the principal's office. The principal asks them to sit down and closes the door behind them.

"I regret to tell you," says the principal, "that a routine locker search revealed an illegal substance in Johnny's locker. In accordance with school policy, both Johnny and the illegal substance have been turned over to the police."

Mrs Smith begins to cry softly.

"We tried to be good parents, we tried to set a good example, we always talked to him when he was troubled,we . . . ."

"There is no point in going on like that Mrs Smith," the principal interrupts, "because I spoke to the boy before the officers took him away. I know his awful secret. That poor child does not know how to access a database. He doesn't know a modicum about modems, let alone baud rates. It's a pathetic case, really. I asked him what bits and bytes were and he said they were some kind of snack food!"

"What are you saying?" asks Mr Smith.

"I'm saying that you have raised a computer illiterate," says the principal.

"A what?"

"A computer illiterate — a being as unsuited to the last quarter of the 20th century as the dinosaur was to the ice age. No wonder he has no self-esteem, no sense of self-worth. He doesn't even know the basics, and by that I mean BASIC. Not that that would help him much — he tells me all his friends are into Pascal, APL, and Forth. Is it any wonder that this poor, deprived child has turned to drugs for solace and comfort?"

"We gave him our time, and lots of love . . . ," mumbles Mr Smith.

"That's software," cries the principal, banging his hand upon the desk. "What good is software without the hardware?"

"We bought him the Atari," says Mr Smith defensively.

"You bought him an Atari," says the principal in a mocking tone of voice, "a cheap little cassette-driven gizmo that plays Space Invaders and E.T. Come Home. You bought him an Atari when what he needed was 64 kilobytes of random access memory, a good disc-drive, and a serial I/O port! At the very least you should have got him something he could sink his teeth into — a 48K Apple for instance, with an expansion board for color graphics so he could creatively interface with it."

"We encouraged him to expand his mind; we got him a library card . . . ."

The principal cannot believe this. He just cannot believe it."A library card! Do you mean to tell me you actually encouraged him to interface with the world in a Gutenberg manner?"

Mrs Smith begins to weep openly.

"Is it too late for him?" she asks through her tears.

"Perhaps. Perhaps not. The boy does speak English. We could build on that, use it as a tool to help him learn a useful language like COBOL or FORTRAN. He'd never be able to program in machine language, of course, but I imagine he could get by in a marginal sort of way. I'll tell you what. I'll speak to the judge. Maybe we can arrange it so he can serve out his time at camp."

"Oh that's just what he needs: fresh air, sunshine, and good healthy fun in the out-of-doors," says Mrs Smith.

The principal leans back in his chair and rolls his eyes.

"I don't think he means that kind of camp," says Mr Smith, putting his arm around his wife's shoulder and escorting her out the door. "He means a computer camp."

After the Smiths leave the principal calls in his secretary.

"Bring in that literature on the battered child," he says. "Maybe I should be reporting this case to someone in authority."

NEWS

RESEARCH UPDATE

Beer and beri-beri

Heavy beer drinkers face the risk of developing cardiac or "wet" beri-beri because of an acute thiamine deficiency. Three researchers from the division of medicine and department of biochemistry at Stobill General Hospital, Glasgow, reported on the first two documented cases of cardiac beri-beri in Scotland caused by heavy beer consumption. In both cases the men aged 38 and 43 years, had heavy daily consumption of beer (eight to 10 pints) and diminished food intake. K. F. Whyte, M. G. Dunnigan, and W. B. McIntosh reported that in both cases thiamine intake was extremely low. "Beer contains virtually no thiamine calories and an intake of thiamine deficient calories from this source accounts for the absence of malnutrition." The researchers said "wet" beri-beri should be considered in any patient with heart failure of obscure etiology.
Scottish Medical Journal, Oct 1982, vol. 27:288-291

Anorectics and caffeine

Anorexia nervosa sufferers are susceptible to caffeinism, a Columbia University doctor has reported. John Sours, MD, described a 16-year-old anorectic girl who admitted drinking four to six quarts of diet cola daily and a 34-year-old woman who began to drink up to 12 cups of black coffee and a gallon of diet cola daily following the birth of her baby. Dr Sours said diet colas are especially popular with anorectics "because they provide a sweet-tasting, low-calorie drink in a potentially unlimited quantity for the self-starving individual." He said the depressive effect of anorexia pushes patients to caffeine-laced drinks to the point that caffeine symptoms become dominant.
American Journal of Psychiatry, Feb 1983, vol. 140:235-236.

Brain damage in alcoholics

Withdrawal seizures are not indicative of the extent of neurological damage in alcoholics, conclude researchers from the department of psychiatry, Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine. They studied 34 alcoholics referred for neuropsychological testing; the 12 alcoholics who experienced withdrawal seizures performed comparably to the 22 who detoxified without seizures on a number of intellectual and neurophysical tests. Both groups, however, experienced a number of impairments. The study concluded withdrawal seizures "are not a marker for the severity of cerebral damage," and "cognitive and perceptual-motor capacity assessed during abstinence are unrelated to the severity of central nervous system disruption that occurred during detoxification."
Journal of Nervous and Mental Disease, Feb 1983, vol. 171:123-125

Cannabis and psychosis

A South African study of 20 psychotic men suggests a high cannabis intake may be related to a type of rapidly-resolving psychosis. Researchers from the University of Cape Town Medical School and Groote Shur Hospital matched 20 men admitted to the Valkenberg Psychiatric Hospital and found to have high urinary cannabinoid levels, with 20 cannabis-free controls also admitted to the hospital. The patients with high cannabis levels showed a significantly higher occurrence of hypomanic symptoms and agitation, but one week after admission they showed marked improvement, while the controls were virtually unchanged. The five investigators concluded further research was necessary to determine whether cannabis causes the psychosis or precipitates the illness in predisposed individuals.
The Lancet, Dec 18, 1982, n 8312:1364-1366

Alcoholic diet bias

A University of Washington study questions the belief that all alcoholics hospitalized for treatment are malnourished. Twenty-five patients without significant liver disease admitted to the alcohol treatment program at the Seattle Veterans Administration Medical Center were given an extensive series of biochemical and anthropometric tests. Nutrient intake data were also collected. No abnormalities in visceral protein were seen, and the patients were not judged to be malnourished. The researchers said few studies have dealt with the nutritional status of patients with alcoholism as a primary diagnosis. "This leads to a biased view of the nutritional status of the 'typical alcoholic,'" the study said, and "the role of malnutrition in alcoholism is obfuscated by organ dysfunction." The investigators concluded severe nutritional deficiencies are not rampant among patients hospitalized for alcoholic treatment and suggest nutritional assessment of these patients need only include a diet history and an initial screen of biochemical indices.
American Journal of Clinical Nutrition, Feb 1983, vol. 37:216-220

Alcoholics antisocial

A strong relationship between alcoholism and antisocial personality has been found in a survey of medically hospitalized inpatients. The study by Drs Collins Lewis, John Rice, and John Helzer of the department of psychiatry, Washington University School of Medicine, and Jewish Hospital of St Louis, St Louis, MO looked at 412 patients. Antisocial patients had a significantly higher prevalence of alcoholism than non-antisocial subjects, and antisocial men had a significantly higher prevalence of drug dependence. Even when the overlap symptoms for antisocial behavior and alcoholism (police trouble, fighting, and job difficulty) were eliminated, the relationship remained significant. The anti-social personality was more likely to be exposed to problem drinking and, once exposed, tended to be more susceptible to developing the full alcoholism syndrome.
Journal of Nervous and Mental Disease, Feb 1983, vol. 171:105-113

MDs and patients need warning of risks in chronic analgesic use

By Harvey McConnell

WASHINGTON — Chronic use of heavily-advertised analgesic compounds containing acetylsalicylic acid (ASA) or acetaminophen can lead to irreversible kidney damage.

The advertisements carry the rider "see your doctor if pain persists." However, the chief message, often delivered by well-known actors, conveys to consumers and doctors the idea analgesics "are entirely safe for long-term use," charges William Bennett, professor of medicine and pharmacology, Oregon Health Sciences University, Portland.

He said as many as 10% of patients who have end-stage renal disease, and need either a kidney transplant or continual dialysis to stay alive, have had their kidneys damaged by chronic analgesic use.

Dr Bennett told a United States National Kidney Foundation symposium here that if analgesics are used as directed and over a short period they appear to be quite safe. Long-term use is different.

Renal damage is cumulative and it is estimated it takes about two kg ingested over a long period of time to cause serious damage.

Dr Bennett said the typical patient with end-stage renal disease from analgesic abuse is a middle-aged woman who started taking the compounds for such conditions as headache or low back pain and has continued to use them for years. Many of these patients are classed as depressed or anxious. Quite a number are heavy smokers. They often combine analgesic preparations and use laxatives as well.

Dr Bennett said Canadian officials banned the use of phenacetin as an analgesic in compounds in 1973. It is believed a subsequent lowering of the incidence in Canada of end-stage renal disease was a result of that ban.

In the US, phenacetin will be banned from all analgesic preparations by the end of the summer, although many makers have already removed it from combination tablets.

A major problem is that diagnosis of the condition can often be delayed because the damage is done silently.

Dr Bennett said if the patient is caught in time, damage can be arrested and sometimes even slightly reversed.

Both patients and doctors suffer illusions. Many doctors are unaware of the problem, and most patients, if asked, would not even consider they were taking drugs.

Dr Bennett said more needs to be known about preventing kidney damage. There has been only one prospective study of the effects of an analgesic used over a period of time. The study of 623 working women age 30 to 49 years who used phenacetin for 11 years, found 33 died of end-stage renal disease. This was three times the death rate of a control group of women who did not use phenacetin.

Methadone no longer used

Drug clinic favors acupuncture

By Lynn Payer

BRONX, NY — Acupuncture and other natural healing methods have been so effective in treating substance abusers that New York City's first outpatient, methadone detoxification program stopped using methadone in 1978, says Michael Smith, MD, director of the Substance Abuse Division of Lincoln Hospital.

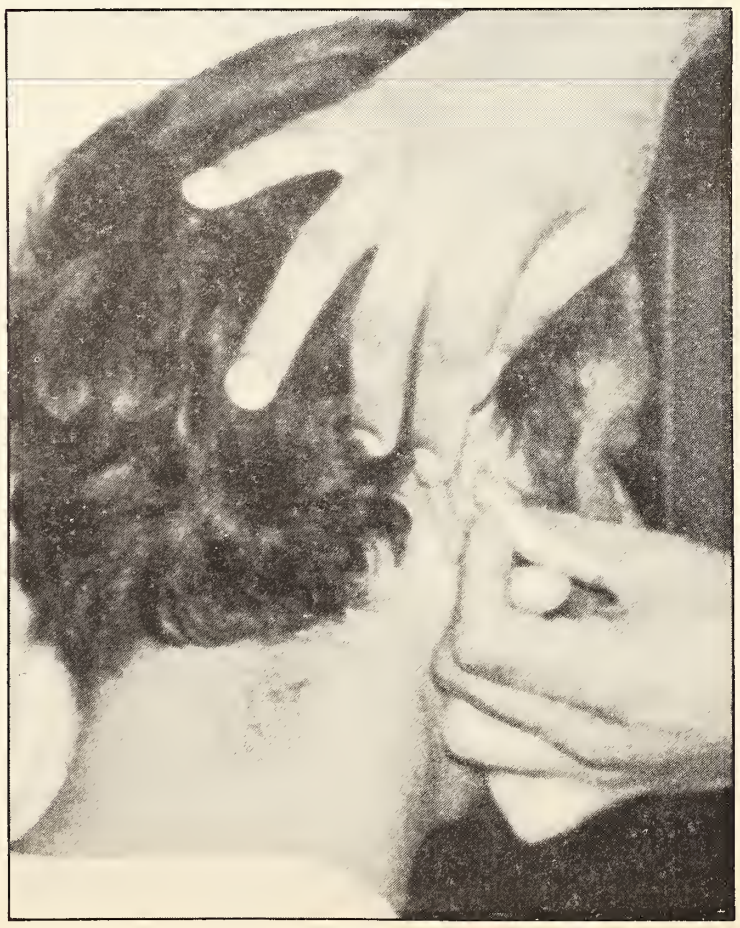
Dr Smith told **The Journal** he occasionally recommends methadone detoxification but doesn't offer the drug because other clinics in New York have methadone programs. He says his division, which started using acupuncture in conjunction with methadone in 1973 and dropped the methadone altogether five years later, has become calmer and more effective without the drug.

The clinic, in the South Bronx, now treats more than 200 patients a month on a drop-in, no-appointment basis. "We take anybody" Dr Smith said.

"Acupuncture is not harmful, it's not illegal, and it's not expensive."

He said surveys have shown acupuncture provides 90% relief of symptoms. And, 90% of patients return for a second visit, with no incentive other than the relief given by acupuncture. Dr Smith estimates approximately 50% complete the recommended number of visits, which varies for each individual. Those who do complete the series of treatments over the acute, two-week period remain drug- and alcohol-free for several months, he estimates.

In most cases, ear acupuncture is used. Treatment is the same no matter what substance is abused, although it may vary somewhat, depending on the patient and the symptoms. The needles are inserted and patients are told to relax and, if possible, to sleep, in the waiting room.



Acupuncture: not harmful, not illegal, not expensive

The most frequent cause of treatment failure, he said, is the patient's inability to relax during acupuncture.

Dr Smith enumerated several ways he considers the treatment particularly advantageous to the substance abuser:

- Because acupuncture is safe and non-addicting, the clinic does not need to apply legal and security measures necessary with methadone. Administration is rapid, inexpensive, and can be performed on demand. Such considerations minimize the barriers to treating the relapsed patient.
- Since acupuncture points are selected according to the overall status of the patient and not according to the particular substances being abused, it is not necessary to know the patient's current drug status. Thus, "pressurized encounters" with clients about their drug use are avoided.
- Acupuncture relaxes patients, making them more receptive to psychotherapy that might address their long-term problems. In contrast to the methadone clinic, Dr Smith said, where patients were often hyperactive and agitated, the acupuncture clinic is usually calm. Drug abuse counsellors, he said, "spend a lot of time talking to patients who are not able to listen to suggestions."
- As acupuncture can be used for other complaints, substance abusers are encouraged to bring spouses and parents with them for treatment. Dr Smith said it is common for addicts to receive treatment at the same time as their parents are being treated for arthritis. This facilitates family therapy and reduces the stigma for the addict.

Dr Smith cautioned that staff should have previous experience in treating substance abusers.

"Merely establishing a room staffed by acupuncturists who do not have personal experience in substance abuse treatment and ongoing support from staff in other program components has *not* been shown to be effective," he said.

Drunk drivers get halfway house rehabilitation

By Mark Kearney

TORONTO — Impaired drivers who would otherwise be serving time at a correctional centre are living at a halfway house here watching educational films, participating in group therapy, and trying to understand their criminal behavior.

The ministry of correctional services and the Mimico Correctional Centre sponsor the program — the first of its kind in Ontario and perhaps anywhere —for men who may benefit from the halfway house lifestyle.

The program is scheduled to run a year and, if successful, may be expanded to other parts of Ontario. Only men participate but women may be included later.

Most of the drivers are second or third offenders and would normally be serving a 60- to 90-day sentence at the correctional centre. Instead, they spend four to six weeks at Madeira House, in the city's west end, where they are counselled on the dangers of driving while impaired.

Ramsey Kane, executive director of Madeira House, says the new program should work because similar approaches have been successful in the community in the past. For the past five years, under the ministry, Madeira House has offered counselling and self-help programs for men who have committed alcohol-related crimes.

The new program is geared specifically to impaired drivers and staff spend more time than before with those convicted, says Mr Kane.

Approximately 15 men live at the house at one time. Each day they go to their jobs and return to the halfway house at night for two hours of group sessions.

During the sessions, the men explore values, set goals, role play, and examine the drunken driving behavior that brought them to Madeira House, Mr Kane told **The Journal**.

Films focus on the problems and results of drinking and driving, he says. Following the films, the men discuss their drinking habits and their attitudes toward driving in general, Mr Kane says.

Families, employers, and possibly representatives from groups such as PRIDE (People to Reduce Impaired Driving Everywhere) may also be involved in the sessions, helping the men come to terms with the consequences of driving while impaired. Mr Kane says the men should have learned not to drink and drive by the end of the six weeks.

"It's one thing to be cogent about (the dangers of drinking and driving). It's another for a person to feel it in his gut and really believe it."

He says those chosen for the program will be screened by staff in consultation with correctional services officials. Anyone at Mimico convicted of impaired driving can apply for the program, but they must be employed and show they're motivated to change their drinking behavior, Mr Kane says.

Madeira House: a new treatment approach for drunk drivers

Graduates of the program and those who have been helped by Madeira House in the past may also be involved in the group sessions, Mr Kane adds.

The program's estimated cost is about $4.50 a day per person above the House's regular budget. Mr Kane says this is cheap considering the recidivism rate will be probably lower than if the men were "sitting in prison doing zip."

One ministry official estimates the daily cost at $32, about $28 cheaper than the cost of keeping a man at the correctional centre.

The men are closely supervised and anyone breaking the rules will likely be sent back to the correctional centre, Mr Kane says.

GILBERT

'. . . pretty tame stuff to Canadian ears . . .'

A not-so-secret report

By Richard Gilbert

One of the worst kept secrets in the alcohol literature is the existence of a confidential report produced for the British government in 1979 by its Central Policy Review Staff (a group known sometimes as the "Think Tank") and kept under wraps ever since.

By last summer the report's secrecy had become the focus of considerable controversy and the subject of two biting editorials in the *British Journal of Addiction*.

The first of these editorials (BJA, March, 1982) suggested that the reason for the report's suppression might be "barefaced political expedience" (**The Journal**, May, 1982), and that the most important alcoholism statistics the government could provide "would then be on the number of Members of Parliament who are in some way connected with the liquor trade or the advertising lobby, and the contribution to party funds which come from similar sources."

The BJA editor advised that he had seen a copy of the report and contemplated publishing the whole thing, but that lawyers had indicated that his position "might not be safe" on account of the British Official Secrets Act. Nonetheless, the editorial went on to describe the substance of the report.

The next issue's editorial (BJA, June, 1982) actually quoted a passage from it. This second editorial mostly concerned a document that the British government had released. Its title was *Drinking Sensibly*, but the BJA felt that it should be called *Alcoholism and Irresponsible Government* because of the way in which it "flouts the evidence and arguments of the Think Tank report in multiple respects."

Publication

Demand for the secret report became such that Dr Kettil Bruun was prompted to publish the whole thing through the University of Stockholm as the first venture of a research project called "Studies in Swedish Alcohol Policies."

Dr Bruun described the British report as "an important contribution to the ongoing discussion on comparative alcohol policies," and singled out three important features:

1. Sixteen departments of the British government have major policy interests in alcohol, indicating a complexity of viewpoints that must be taken into account in the development of alcohol policies.

2. The report includes a noteworthy discussion on the presentation of alcohol to the public. This is the longest chapter of the report and includes sections on advertising and health education.

3. There is a strong attempt in the report to relate economic and health issues.

Since last summer, the report and the controversy around it have become more and more public. It has been mentioned in both the medical and general press in Britain. BBC Television is planning a documentary feature on it. In Canada, *The Medical Post* recently published an item referring to the report. Alan Massam, **The Journal**'s London correspondent, necessarily refers to it in a commissioned article on alcohol policy in the UK that appears on The Back Page this month.

Confidential

The report itself, dated May, 1979, comprises exactly 100 pages with just over half as many again of appendices and other material. The word CONFIDENTIAL appears at the top of every page. The report's conclusions and recommendations are summarized in the introduction as a seven-point program for early action:

1. The government should announce a positive commitment both to stop the rise in consumption levels and to reduce the incidence of alcohol-related disabilities.

2. This approach should be interpreted widely with particular regard to public attitudes. It should involve reviewing the impact of pressures in the media and health education on drinking habits, particularly among the young and women. It should influence alcohol policies generally, not just those concerned with the health consequences of misuse.

3. The trends toward making drink cheaper resulting from the lag in revenue duties should be arrested. As a minimum, duty levels should be kept in line with the Retail Price Index.

4. Liquor licensing should not be further relaxed. Its purpose should be clarified and its enforcement improved, especially with respect to under-age drinking.

5. A program should be adopted on alcohol and work. The government should take a firm lead in clarifying issues, assembling facts and experience and disseminating them, and setting an example as a major employer.

6. There should be renewed action against drinking and driving. Legislation should be prepared.

7. The government should establish an Advisory Council on Alcohol Policies and give it an activist role, not only to advise and comment but also to encourage and monitor action. The activities of national bodies should be rationalized, and responsibilities at a local level clarified.

Tame stuff

This is all pretty tame stuff to Canadian ears. There is little here, for example, that is different from what the Addiction Research Foundation has been saying to the Ontario government for years. The only striking difference is one of emphasis. For example, there is nothing about the treatment of alcoholics in the seven-point program. The brief chapter on "Helping Alcoholics" ends with the curt conclusion that "treatment is not an answer to alcohol problems: services cannot cope now, and are never likely to be able to; not all those offered treatment will benefit."

Because I was working on taxation and tobacco consumption last year, I was particularly interested in what the report had to say about the taxing of alcohol and its role in regulating consumption. Data are provided that suggest widely varying elasticities of demand according to the type of beverage. The numbers indicate that, other things being equal, a 1.0% increase in real price would produce a 0.2% decrease in per capita beer consumption, a 1.1% decrease in wine consumption, and a 1.5% decrease in liquor consumption.

These figures suggest to me that beer consumption in Britain is relatively insensitive to changes in price but that consumption of wine and liquor is extremely sensitive. (Recent data indicate that in Ontario, by comparison, beer and liquor consumption are moderately sensitive to price, and that only wine consumption is extremely sensitive.) Wine and liquor accounted for just 26% of the consumption of alcohol in Britain in 1976, but comprised 43% of the increase in alcohol consumption between 1957 and 1976 (the change was from 6.2 litres to 10.5 litres of pure alcohol per person). Thus an overall increase in price might have had a dramatic effect. Also, the price of beer had increased very much more than the price of liquor and wine.

The report recommends the linking of alcohol duty levels (and thus, presumably, prices) to the Retail Price Index, as noted above. This would be the minimum action. The report also concludes that taxation be used as a means of regulating consumption: "the criteria for determining duty levels should be changed to reflect the government's stance on total consumption levels."

Irony

The report paints a dramatic picture of alcohol use and abuse: "the consumption of alcohol has increased to the highest levels for over half a century . . . indicators of alcohol misuse are also at record levels . . . the rising consumption of alcohol will continue . . . the trends in misuse justify government concern."

Ironically, the report appeared just as consumption of beer — still accounting for more than 75% of Britain's alcohol use — seemed to be reaching a plateau. Preliminary data indicate that per capita consumption in 1981, at 206 pints per person, was below the 1976 level of 209 pints — no doubt a consequence of Britain's desperate economic predicament.

According to other figures I have, wine consumption may be stabilizing too, but liquor consumption, accounting for about 15% of total alcohol use, may still be on the increase. (Very preliminary data on British beer for 1982 suggest a sharp decline in consumption — by more than 10%.)

A significant omission from the Think Tank report would appear to be discussion of the benefits of alcohol use, particularly the health benefits that appear to accrue from regular, moderate consumption of alcohol. As I discussed in an earlier column (What do we do about alcohol? **The Journal**, May, 1980), a government that is working out what might be the most appropriate overall level of alcohol use for a community should balance both the costs and the benefits associated with different levels of use. The Think Tank report does a good job of balancing health and social costs with supposed economic benefits, but it ignores possible health benefits.

Dire economic straights may be doing in Britain what government advisers told government to do —curb alcohol use. The mystery is why a report of this nature had to be kept secret.

NEWS

Painkiller sales on increase
Cdn drug statistics reveal

TORONTO — Canadians may be taking fewer tranquillizers and sleeping pills but they are using more painkillers, suggest drug sales data included in the just-released annual statistical report of the Addiction Research Foundation (ARF) here.

The data were compiled by International Marketing Services (IMS) of Canada and made available for the first time for inclusion in the ARF's *Statistics on Alcohol and Drug Use in Canada and Other Countries*. They deal with the sales volume of psychoactive ethical and proprietary drug products to drug stores and hospitals for use and resale.

The IMS figures cited in the ARF report indicate that, in terms of drug units sold (wholesale), there was a general increase in sales of analgesics between 1977 and 1981 while sales of psychotherapeutics — mainly psychostimulants, tranquillizers, and non-barbiturate sedatives — generally decreased during the same period.

In the analgesic category, proprietary, non-narcotic analgesics were the biggest sellers with 489 million units sold to drug stores in 1981, an increase of 31.8% from 1977. Also popular was acetylsalicylic acid (ASA) with 245 million units sold to stores, an increase of 56.6% in the same period.

But figures on drug store and hospital purchases of tranquillizer units seem to indicate an opposite trend in the use of psychotherapeutics. For instance, drug store purchases of minor tranquillizers decreased 6.6% in the 1977 to 1981 period. In hospitals, the decrease was 19.4%.

Manuella Adrian, head of the ARF's Statistical Information Section which compiled the report, says the decrease in the sale of tranquillizers by both hospitals and drug stores may indicate a growing reluctance on the part of doctors to prescribe minor tranquillizers, as well as greater consumer awareness of the effects of the product.

She cautions, however, that figures showing a decrease in the use of tranquillizers and an increase in the use of painkillers must be seen in conjunction with other data on personal drug use, retail drug sales, and prescriptions filled.

In addition to the IMS survey data, the new ARF report contains a variety of data not previously available or compiled, including:

- disability pensions paid for alcohol- and drug-related conditions;
- family expenditures on tobacco and alcohol;
- a comparison of growth rates of consumer price indexes of alcohol and tobacco to the CPI for all goods and services;
- voluntary and involuntary admissions to mental hospitals and psychiatric units for alcohol-related conditions;
- a statistical picture of the economic importance of tobacco production and distribution; and
- availability of licenced, on-premise liquor consumption facilities by regions of Ontario.

The annual report, which is compiled from a variety of sources, is intended to provide an overview of the nature, extent, and consequences of substance use in Canada, particularly in Ontario, and a brief overview of international trends.

The cost of bad habits is soaring
Healthier lifestyles could cut future health bill

OTTAWA — Canadians could ease the burden on their health care system over the next 50 years by drinking and smoking less, says a Statistics Canada official.

Doug Angus, chief of research and analysis in Statistics Canada's health division here, says if current lifestyle trends continue, in 50 years time the 20% of the population beyond 65 years of age could be consuming 60% of hospital resources.

In 1976, 8.7% of the population was 65 and older and consumed 38% of hospital resources.

He was commenting on data in the recently released *Perspectives on Health*. The 110-page document is one of a series of analytical and research studies by Statistics Canada on issues and problems of interest to policy makers in health services.

Lifestyle is a large contributor to the incidence of disease in Canada, Mr Angus says, and positive changes can be an important preventive step.

While the report presents no new statistics, it places them in the context of what effect they might have on the future, Mr Angus says. Statistics Canada cannot offer solutions, but it can raise questions for consideration by the public and health policy makers, he says.

The report notes that one Canadian drinker in 20 is an alcoholic, and that 11% of Canadian deaths are related to alcohol. Three in 10 Canadian adults smoke and drink, and more than 600,000 of these people smoke at least 23 cigarettes a day and consume 14 or more alcoholic drinks a week.

The report also notes that sex differences in smoking behavior are almost non-existent in the 15 to 19 years age group.

"This certainly does not bode well for the future, and certain traditionally male diseases, especially cancers and cardiovascular diseases, can be expected to become increasingly common among females," the report says.

Mr Angus told **The Journal** he's not sure if government can tell people to cut back or eliminate their drinking or smoking, but it must consider the social costs of such habits. The government can provide information and promote healthier lifestyles, he adds.

Mr Angus says such promotion is already having an effect. Almost half the population now has a good level of fitness, and government programs, such as Participation, have contributed to this.

Thai health care program doing 'more with less'

(from page 1)

lar projects established earlier in Thailand (**The Journal**, Feb, 1977). In 1975, Mr Archibald, on behalf of the WHO, worked with Thai authorities to plan and develop a pilot health care program in the area.

Parallel to the health project, the Food and Agricultural Organization devised a program to determine what crops could be substituted for the opium poppy.

In 1980, the ARF — now with funding from the CIDA and working with the Institute of Health Research at Chulalongkorn University in Bangkok —extended the project to about 30 key villages and additional neighboring or satellite villages, concentrating again on basic public health education and treatment (**The Journal**, Aug, 1980).

About 3,000 more villagers are expected to benefit almost immediately from the new project; ultimately some 100,000 villagers will be served as they too adopt the principles of health care, says Mr Archibald.

Vichai Poshyachinda, MD, director of the drug dependence program at the Institute of Health Research, Bangkok, is chief of the CIDA-funded development team.

Archibald

Vichai

"It is fundamental that the village population be as deeply involved as possible in the decision-making process and in the development of the program," he says.

Villagers are encouraged to select their own health care worker and participate in building the simple health and training facilities. This is seen as part of the training exercise. The structure is also built in such a way that it may be easily and cheaply replicated in other villages, he says.

As hill tribe people believe evil spirits cause most of their problems, says Dr Vichai, the Thai development team works closely with the local village healers. Herbal medicines from plants in the area are also occasionally used.

Dr Vichai stresses the development workers learned early that the health care program must be part of a more comprehensive development program.

"For example, as infant mortality is reduced by better health care delivery, there is an increase in population and thus a greater problem providing an adequate supply of food."

Additional program components have gradually been included such as family planning, immunization, nutrition, and public health education.

On the agricultural side, the primary objective of the new CIDA project is to improve nutrition, says Mr Archibald. Crop substitution itself is still essentially financed through the United Nations and various bilateral aid programs. However, kidney beans and mountain rice have already been successfully grown in the area and serve both as cash crops and food. A third crop, coffee, is most successful in terms of cash. Income from coffee in some of the villages in 1981 was about nine times the income the previous year from opium.

But crop substitution "will take time," says Katchit Choopanya, MD, director of the drug abuse and treatment division of the Bangkok health department.

Villagers have a long tradition of growing poppies and a change in attitude, especially among the older generation, won't happen readily (**The Journal**, Nov, 1982).

Dr Katchit told **The Journal** the crop replacement that has already taken place in Thailand has done much to reduce the amount of opium grown in the villages. However, there's still a lot of opium moving into Bangkok, where there are an estimated 300,000 to 600,000 addicts, and "it's a tough and difficult battle" to keep the problem from worsening, he says.

Eliminating opium as medicine is the other major hurdle, he says.

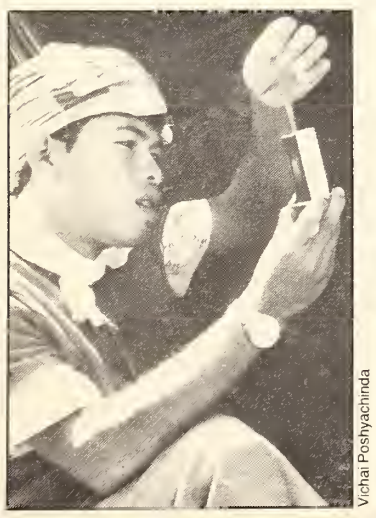
However, the Thailand government is committed to improving health care and drug awareness, and many younger people are realizing that other medicines can work better and more safely than opium, he says.

Dr Katchit and other Thai officials, including Mittira Srivorakul of the Office of the Narcotics Control Board, were in Toronto in March to study drug treatment techniques and methodologies at ARF's School for Addiction Studies. The training program was sponsored jointly by the WHO and the United Nations Fund for Drug Abuse Control (UNFDAC).

The CIDA has also spent almost $100,000 over three years to train professionals in the addictions and public health fields in Nigeria. Now in its second year, the program has stimulated new treatment programs and ways of approaching drug problems, says Donald Meeks, director of ARF's School for Addiction Studies, and consultant on the Nigeria project which is being carried out in association with the International Council on Alcohol and Addictions and UNFDAC.

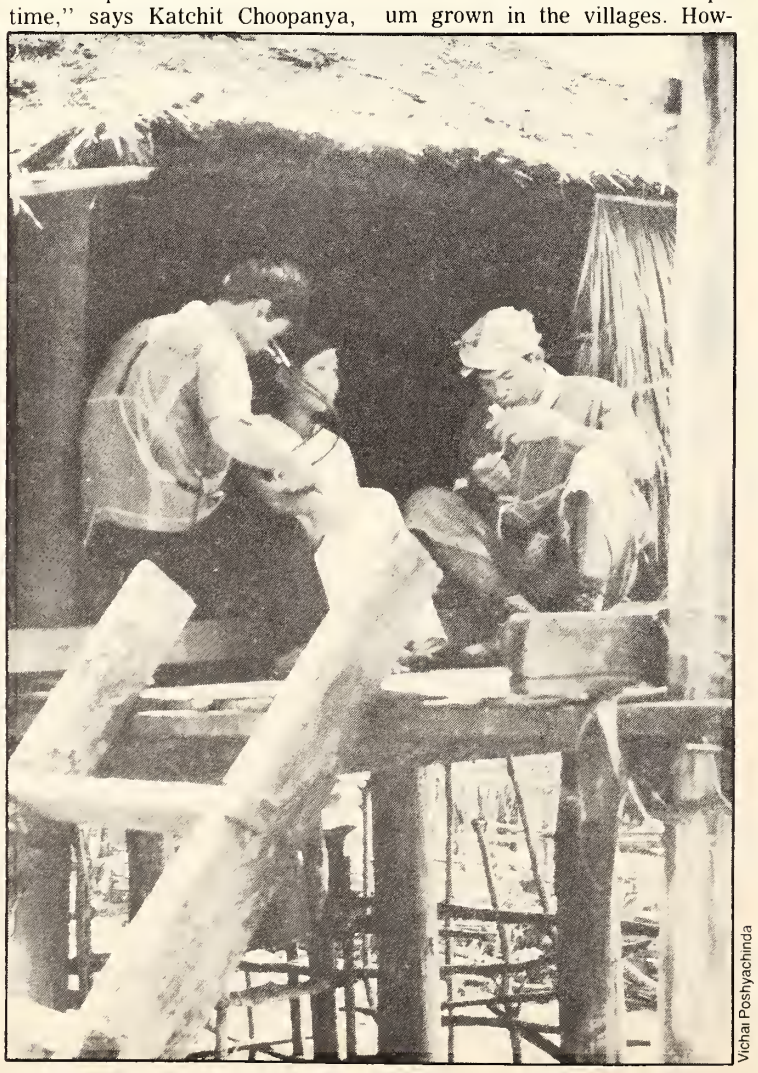
This program and the ones in Thailand are important because of their long-term effects in battling the world drug problem, Dr Meeks says.

"All these things operate on a two-way street. People in developing countries have had to learn innovative techniques in the absence of large resources. They may be well ahead of us in learning how to do more with less. Therefore, we're learning from them as well as providing information (to them)."



Vichai Poshyachinda

Village medic: adopting the principles of health care



Vichai Poshyachinda

Health unit: easily built and cheaply replicated in other villages

FEATURE

US colleges focusing more on student drinking

Faculty most resistant to prevention, treatment

By Harvey McConnell

CHICAGO — Social drinking — plus the occasional binge — is a part of college life. For a small number of students, alcohol creates trouble.

However, while the evidence indicates most students complete college without serious difficulty with alcohol or other drugs, the current move to raise the drinking age in many states in the United States, and the US campaign against drunk driving (**The Journal**, May, 1982) are focusing more attention on student alcohol use.

Programs to teach students how to make responsible decisions about drinking are being initiated in a number of US colleges and universities. One — BACCHUS (Boost Alcohol Consciousness Concerning the Health of University Students) — now has 95 chapters on college campuses across the country.

Nevertheless, starting student programs is not easy, experts agreed here at a conference on alcohol and drug abuse programming in colleges and universities. It was sponsored by the Alcohol and Drug Problems Association of North America.

And while some progress has been made, the rock of resistance appears to be faculty; only a minority will seek assistance for their drinking problems, and then, reluctantly, says Richard Thoreson, PhD, of the University of Missouri, Columbia, MO.

But how serious is student drinking?

Although there is an increase in heavy drinking by female students, patterns have changed little between 1974 and 1982 said Ruth Engs, EdD, associate professor, department of health and safety education, Indiana University, Bloomington.

Dr Engs found little difference between two, nationwide surveys she conducted in 1974 and 1982.

Heavy drinking by male students rose from 20.3% to 24.8% during the eight-year period. Among female students the rise was more dramatic: from 4.4% to 11.5%.

"Drinking among college students has always been around, but it is not a really serious problem overall. Although alcohol use appears to have remained about the same, there is more focus on it now," she added.

Dr Engs said the increase in heavy drinking among women students can be attributed to social and cultural factors and more readiness to admit to drinking problems today.

Dr Engs: "I think there is a lot of pressure on women, which pushes them toward heavy drinking. More and more they are being treated as 'one of the boys' and more often go to bars after classes."

Gerardo Gonzalez, PhD, a founder, and now president of BACCHUS, outlined three tenets for a successful program.

The first is a consensus among students, faculty, and administration that a program is needed. "Most college students are interested, helpful, and health conscious, and they will respond to a positive message about things they can do to minimize risks."

The second essential is serious institutional commitment. "We are not going to solve this problem with an alcohol awareness week, or a poster campaign, or a workshop, or any other once-a-year event It is going to take a comprehensive and sustained effort," Dr Gonzalez said.

Thirdly, there must be student involvement. "Without this the chances for success are minimal. It has got to be a partnership between students and the institute."

Dr Gonzalez is also dean of students and director of the campus alcohol centre at the University of Florida, Gainsville where the program was developed. He said the focus on drugs in the 1960s made alcohol appear to be acceptable, yet, by comparison, problems caused by alcohol abuse are much greater than those caused by all the illicit drugs combined. A focus on alcohol can provide guidelines and standards, something very difficult to do with illicit drugs.

Bruce Donovan, PhD, associate dean of chemical dependency, Brown University, Providence, RI, agreed that campus programs should be specific to alcohol.

"If you have a drug program, and it is so advertised, and you only deal with alcohol, then I think your credibility is threatened. If you say you are going to deal with alcohol and do it well, nobody is going to nail you for not dealing with cocaine."

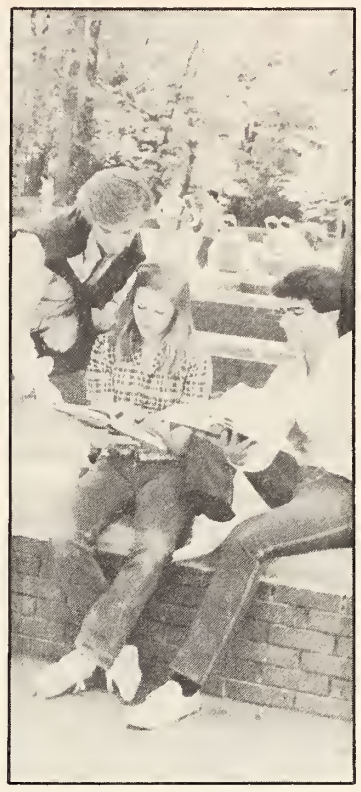
Dr Donovan, who started an alcohol program at Brown on a shoestring seven years ago, said every source — especially those that are free — should be utilized: AA (Alcoholics Anonymous), Al-Anon, campus newspapers, posters from a variety of organizations, and local television and radio.

"And perhaps the most important is a one-sentence statement of support from the president of the university, making it clear that when alcoholic beverages are served, then non-alcoholic beverages are served as well. This makes it clear to the community we mean what we say when we encourage moderation."

Dr Donovan added that efforts should be made to "scotch out fast" faculty poster invitations to wine and cheese parties and sherry hours "which are somehow okay for faculty but inappropriate for students."

Dr William Eck, EdD, is associate professor of health education at Penn State University, State College, PA, and co-director of TAAP (Total Alcohol Awareness Program). Since he started the TAAP in 1979, faculty and staff from 18 other Pennsylvania campuses have been trained.

Dr Eck: "The key to our strategy is the assumption that programs which set out to change attitudes and practices must work through non-judgemental approaches to get the individual's attention, and to raise his or her awareness. The emphasis is on responsible decisions for people who choose to drink beverage alcohol."



Women: there's more pressure

James Dean, PhD, is coordinator, office of chemical use and abuse at the University of North Dakota, Grand Fork. He said there has been a subtle approach in the substance abuse field, "that if we simply give people information it will affect their attitude and therefore their behavior will change. This seems a logical series of steps when done under experimental conditions, but it does not work."

Success can be a problem, said Dr Dean. "You can get on a run with a good program, and people take it for a while, but later they begin to say 'Oh, we've had that program, we don't want that.' They have what I call prevention saturation."

He added there must be constant development of new techniques. "It is a lot of work, but it is fun, and it is fascinating to be involved in new programs."

A counselling centre with knowledgeable staff is a necessity, said Cynthia Lewis-Shaffer, assistant director of the campus alcohol information centre, University of Florida, Gainsville.

She said staff should also be aware of outside resources because "often the university is set aside from the community and we don't interact as much as we can."

At Gainsville, student volunteers are encouraged to read the literature, attend an AA meeting, or attend a school for those convicted of drunk driving.

Ms Shaffer: "We need to educate counsellors and volunteers completely, and not halfway. They need to be given the whole picture."

The environment in which alcohol is sold on campus is something which should be studied to avoid excess pressure on students to drink.

Gail Gleason Milgram, EdD, director of education, centre of alcohol studies, Rutgers University, New Brunswick, NJ, said there should be a choice of non-alcoholic beverages in the same quantities and sold at the same distribution point as alcohol within the pub. Equally, students should have access to food service when drinking.

Time and experience have shown that the group most resistant to using alcohol prevention and treatment programs are faculty members.

Dr Thoreson is professor of educational counselling and psychology at the College of Education, University of Missouri. Between 1975 and 1982, he received a grant from the occupational program section of the US National Institute on Alcohol Abuse and Alcoholism to launch a prototype employee assistance program for faculty and staff.

While the program has been successful in helping members of the university staff and their families, "faculty will never come in numbers proportionate to their numbers in the workforce."

Only some 22% of the faculty and family members who appear to need help have actually sought it.

There were, and remain, strong pockets of opposition to the program, including many psychologist colleagues.

Dr Thoreson: "It is important at the beginning to identify your advocates, and your critics, and work out a plan to get maximum support from your advocates while trying to minimize the effects of your critics."

Among faculty members and families who have come to an off-campus health agency to discuss personal or professional problems, about 40% had alcohol problems.

Department heads who confront faculty members whom they consider need assistance are always told by Dr Thoreson not to expect thanks: "They will try to undercut or sabotage you in order that they can continue to drink. They will claim you have it in for him or her, or that you are phobic about drink."

Useful levers to try and get faculty members, including tenured staff, into treatment are to state that if work performance does not improve travel funds will be cut, key committee assignments will be withheld, or a recommendation will be made by the department head that there be no salary increases.

Campus life: only a few students have drinking problems. Most are 'interested, helpful, and health-conscious'

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Coverage excellent for RCMP estimates

I am writing to express my sincere appreciation to **The Journal** for your excellent coverage of the release of the Royal Canadian Mounted Police (RCMP) National Drug Intelligence Estimate (NDIE) (**The Journal**, Feb).

The article by Mark Kearney "RCMP release drug intelligence estimates . . ." provided a good overview of our publication and was very well written. As well, the graphics for the front and The Back Page articles were professionally presented and, I feel, highlighted and created greater interest in the articles.

I look forward to reading articles dealing with drug law enforcement and drug abuse in upcoming issues of **The Journal**.

Rodney T Stamler, Supt
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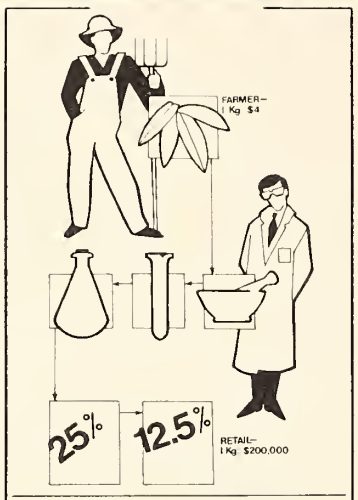


From coca leef to gold dust
Drug income rises dramatically from source to street sale. Processed and cut to 12.5% purity, cocaine sells for about $200,000 per kg on North American streets. For his coca leaves, the South American farmer got $4 per kg.

Lions respond . . .

...from Ireland

Thank you very much for the March issue of **The Journal**, which I read with interest, although I notice that the Social Services Secretary here in the UK makes some very strong statements on page 3.

I believe that the Lions throughout the world must be enthusiastic yet careful, and our main assistance in this terrible scourge will be that of educating and making people aware of the dangers of drugs.

You will probably be glad to hear that Lions Clubs International with its 1,350,000 members worldwide, will be carrying this Drug Awareness project forward for at least the next four years.

Hubert A Mason
Second Vice-President
Lions Clubs International
Donaghdee, Northern Ireland

...from Texas

Just received **The Journal** (March) today, immediately read it, and thoroughly enjoyed the information it contained.

Certainly your communicator is an excellent service. I have thought so much about how the Lions of the world, with other groups, can work together to accomplish the reduction of drug abuse. Here is a vehicle to be plugged into that can do so much good.

I wanted to mention one of the strengths of the program here in Texas which many underestimated until they were involved.

This is the Neighbors' drug awareness party. Even though the invitation states slides will be shown on harmful effects of marijuana, the evening always turns out to be an education on many areas of community needs and problems of crime. Most people end up feeling they have really developed friends among their neighbors.

Thanks so much for your publication, and I am looking forward to working with you in the future.

John Hall
Coordinator Drug Abuse
Lions International
Fort Worth, Texas

...Pennsylvania

Thank you for the March issue of **The Journal**. I plan to show it to several of my associates who have been working on the program. It is a most interesting program and I am sure it will be most helpful. I look forward to the next issue.

Jim Shirley
Lions International
District Governor, District 14-E
North Huntington, PA

Funding continues

I would like to respond to the article, Cash bind forces women's centre to modify addictions programs, (**The Journal**, Dec, 1982).

In a subsequent article, Governments still support Amethyst (**The Journal**, Feb) Dorothy Loranger, program manager of the alcohol and drug abuse section of the Ontario ministry of health, clarifies the government position. However, I would still like to further clarify the original article.

The first two paragraphs accurately quote Sharon D'Arcy as saying that Amethyst is now having to turn to the private sector for funding. This funding, however, is to augment, not replace, the financial support we are receiving from the public sector. Amethyst will continue to rely on the needed financial support received from all levels of government. Such support is vital to continued, successful operation of all our programs. We have every reason to believe that our strengthened partnership with both private and public sector funders will continue.

Secondly, the statement that the centre "once for women only . . . is now also open for co-ed meetings . . ." creates a false impression of our philosophy; Amethyst both provides for family education sessions and remains open to being referral agents for family members. However, our core function is providing treatment for women with alcohol and drug related dependencies.

Tanya Owen
Executive Director
Amethyst Womens Addiction Centre
Ottawa, Ontario

Letters to the Editor may be sent to: The Journal, 33 Russell St, Toronto, Canada M5S 2S1.

Agency orders extra copies

Our agency has been so pleased with your publication, that I would like to order additional copies to go to our Level II Education Facilitators.

Janice Matz
Administrative Assistant
Roanoke Valley Alcohol Safety Action Program
Salem, Virginia

REVIEW

Shaman Woman, Mainline Lady, rich soil unturned

Women, their drugs, and their writing

By Richard Starks

Samuel Coleridge claimed he wrote *Kubla Khan* while he was under the influence of drugs. That's hardly surprising, given that opium (the drug in question) was at that time widely consumed in western society, and that many of the 19th century's more prominent writers were either heavy users or outright addicts.

Coleridge is one of the Romantics whose names are most closely linked with drugs. But among other 19th century writers — from Thomas De Quincey (*Confessions of an English Opium-Eater*, published in 1822) to Edgar Allan Poe — the influence of drugs is almost as strong.

Of course, the chain linking drugs and literature does not stop there. It winds through the last century and far into this one, and along the way it joins such disparate writers as Charles Baudelaire, Aldous Huxley, William Burroughs, Carlos Castenada, and many, many more.

All these writers owe their literary niches, to some extent at least, to their experiences with drugs. They share a successful union between drugs and art.

But that's not all they share — because all of them are men. And that begs the question: Where are all the women writers? Were *all* of them so free of drugs that their work during the last two centuries was completely unaffected? Of course not. But why do we hear so little about them?

One reason is that the use of drugs has always been much more taboo among women than men (George Sand created a minor sensation when, in the 1850s, she dared to smoke tobacco in public), so there has been a strong tendency for women writers to play down their association with drugs. Elizabeth Barrett Browning, for example, so managed to conceal her addiction to opium that few of her contemporaries suspected she was even a user.

But another reason — perhaps the strongest one — is that no one seems to have taken the time to explore the influence of drugs on the writings of women. And until recently, no one has tried.

That one recent attempt is made in *Shaman Woman, Mainline Lady*, a 285-page, eight-by-ten book, published by William Morrow and Company, and written and edited by Cynthia Palmer and Michael Horowitz. They are husband-and-wife directors of the Fitz Hugh Ludlow Memorial Library in San Francisco, which is "the only library in the world exclusively devoted to the literature of mind-altering drugs."

Unfortunately, it's a disappointing book — doubly so, in view of the rich soil of the subject matter and the fact that it is still largely unturned.

The authors talk vaguely of drugs always being associated with "the mystical, intuitive dimension — the forbidden, the mystery of woman," and of opiates that "carry the user to the womb centre of existence." These are meaningless phrases, the lazy writer's way of tossing out thoughts without bothering to form them.

They talk in generalizations and unsubstantiated claims ("approximately two-thirds of opium users in the 19th century were women") and, occasionally, they wander into the realm of the absurd (in one detour, implying that one million women have been tortured or killed as witches because they took drugs and because a male-dominated church wouldn't let them be priests).

But worst of all, the authors insist on dragging in women who have no right to be in the book at all. Enid Blyton (of all people) is identified as a "psychedelic pioneer." Why? Was Enid hooked on drugs? When she was writing all those Famous Five stories about Dick, Julian, Anne, their cousin Georgina, and Timmy the dog, was she floating high at her typewriter on some Mexican mushrooms?

Hardly. Enid is included in this book because at the age of 18 (or thereabouts), a dentist gave her a whiff of nitrous oxide (laughing gas), and many years later she described the incident in a letter to a friend. It had no impact on her writing at all.

And Charlotte Bronte — why is she in this book? She didn't take drugs. But her brother Branwell did. Is this what the authors are trying to prove — that women writers can experience drugs, but only vicariously and only through men?

Sara Bernhardt is also in this book. She once appeared on a London stage when she was high on opium. She fluffed her delivery and cut 200 lines out of the third act. The other cast members were furious. But no one in the audience noticed. As related in *Shaman Woman, Mainline Lady*, this little anecdote says more about the obtuseness of theatre audiences than it does about drugs and women writers.

Then there's Chicago May — a "bawdy Irish-American con artist." She appears in the book because in 1904 she attended a dope party. She didn't participate; in fact, she left the party early. She had little or nothing to do with drugs. And she wasn't a writer. But at least she was a woman, so in a book about drugs, literature, and women, she does qualify on one count. (That's more than can be said about Lewis Carroll, Mordecai Cooke, and a number of other male writers whose work is discussed.)

The authors of *Shaman Woman, Mainline Lady* say they want to show that women have experimented with drugs and have written about drugs every bit as "courageously" and as "eloquently" as men. But by shoehorning in so many women who have no right to be mentioned, they seem determined to shoot down the theory they set out to prove.

That's unfortunate. Because in spite of the faults, there is enough evidence in this book to show that the authors' thesis is, in fact, sound. Along with the many women who should not be included, there are just as many who should be — and who are. Women like Mabel Dodge Luhan, the first person to record a "peyote ceremony in White America" (in Greenwich Village, just before World War I); or Mary Hungerford, the first woman to publish an account of a psychedelic trip.

Emily Hahn is another. In her memoir, *The Big Smoke*, she describes the easy drift into opium addiction, which takes you leisurely down a gentle slope until, standing at the bottom and looking up, you find that the slope is somehow suddenly steep — much too steep to climb.

Elizabeth Barrett Browning (top left), Mabel Dodge Luhan (left), and Emily Hahn (above); 'leisurely down a gentle slope until suddenly, looking up, it's much too steep to climb.'

Some 60 years earlier, another woman — anonymous — wrote a letter to her family physician (later published in *The Journal of Medical Sciences*, Jan, 1899), describing "what a terrible thing opium-eating is." Here, in this one letter, is a ringing condemnation of the medical profession for ignoring the harmful side of the drug, and of the social attitudes that forced her to keep her addiction secret; and here, too, is the story of one woman's struggle against overwhelming odds and of the strength it took to prevail.

These are eloquent accounts of experiences with drugs. And the women who wrote them are writers of merit.

So, unquestionably, is Florrie Fisher. A PhD graduate from a middle-class background in Brooklyn, NY, she began smoking marijuana at a Catskill Mountains resort, then moved up the ladder until she was hooked on heroin. She turned to prostitution to support her $200-a-day habit, was arrested 75 times, and spent the better part of 20 years in jail. She eventually overcame her addiction, became an anti-drug advocate, and in 1971 published *The Lonely Trip Back*, which must surely rank as one of the most effective accounts of life as a junkie that has yet been written.

Fisher

"I have only one good vein left. It's in my neck, and even that vein can't be used for anything but a blood test. If I need a transfusion, an incision down to an artery must be made, then stitched back up . . . .

"But you don't think of this stuff when you're on junk . . . . You think about one thing, getting high. That's why you don't wait until you get into your apartment to shoot, why you have to go into a cafeteria and use water from the toilet bowl, because you can't wait, you just can't wait.

"How do you explain that feeling? It's nothing like getting tight on liquor. . . . Grabs you. That's what it does. You don't slide into a high like you do on booze. Dope seizes you like the hand of a giant, lifting you higher, higher up to his mouth. But the giant doesn't eat you. He kisses you and it feels wonderful.

"After you shoot, there's this rush. It lasts about four minutes. You are all pins and needles. And then, boing, a skyrocket explodes. A lobster couldn't be that hot. It levels off and you feel good. . . . You're nodding, out of it. Zonked.

"That lasts about four hours. Then the euphoria wears off. . . . It starts with yawning. You keep yawning and your eyes begin to tear. Your nose starts dripping. Then you feel sweaty, an odd kind of sweat, not the kind you get if you've been exercising or working hard. It's a damp clammy feeling. You start itching all over. Your head starts thumping, thumping, thumping like you're inside a bass drum when it's struck. If you don't take a fix soon, you're vomiting. You throw up and throw up, and when there's nothing left, your guts are still convulsing with the dry heaves.

"The giant is squeezing the last drop out of you."

Somewhere, there's a good book to be found in the subject of women, their drugs, and their writing.

'Dragged in with little reason'

Enid Blyton

Charlotte Bronte

Sarah Bernhardt

Chicago May

INTERNATIONAL

Hunt and Satterlee: looking at 'the good part of drinking'

Are British pubs a benefit? Maybe so says study team

By Alan Massam

LONDON — Has there been too much research emphasis on the perils of alcohol abuse and too little on the positive benefits of that cultural institution, the English pub?

"Yes," says Geoff Hunt, a senior sociologist at the Polytechnic of North London.

With United States social anthropologist Sandra Satterlee, Dr Hunt is investigating the "culture of drinking" within a typical English village, Linton in Cambridgeshire.

Sleepy Linton, with its timber-fronted houses and thatched cottages, seems almost too typical. But with seven thriving pubs, it is a growing village with a happy mix of long-established families and newcomers.

Dr Hunt said: "We plan to examine the culture of drinking within the community by investigating the customs, rituals, and meanings associated with it.

"The major focus will be the pub as an institution of social cohesion within the community. We will use anthropological field work methods entailing an extensive period of participant observation on the community as a whole.

"This method, by examining other structures and processes such as kinship and social change, will enable the team to situate drinking within the overall community life of the village."

A total of £12,000 (Cdn $22,380) is being provided by the United Kingdom Brewers' Society to support the research which also aims to compare Linton with similar-sized communites in other parts of Britain.

A spokesman for the society said: "While much attention has properly been given to problems associated with alcohol abuse, there has been little methodological research into its normal use and the important part it probably plays in the social fabric of a community."

Dr Hunt said: "It is very difficult to state honestly what is abnormal in drinking when so little is known about what is normal. We hope to remedy this."

And a long-established resident of Linton, Ernie Smith, 84, concurred. "When I first came to Linton in 1933 there were more pubs than there are today," he said.

"It's about time we got some of these scientists looking at the good part of drinking."

Program gets a boost from brewers

Mexico broadens alcohol attack

By Mark Kearney

TORONTO — Alcoholism research in Mexico has received a $50,000 (Cdn) boost from that country's National Brewers Association.

The Centre for Psychiatric and Clinical Neurophysiological Research (CEPNEC) will use the one-year grant to expand research, education, and information about alcoholism; train personnel for research; and develop courses for professionals who deal with alcohol problems.

Luis Berruecos, PhD, CEPNEC's general coordinator, told **The Journal** the grant is vital because alcoholism is the "most important public health problem in Mexico today."

The $50,000, while not a great deal of money, will go a long way in Mexico in establishing a strong research base, he says.

The CEPNEC was established last year to contribute to the national effort against alcohol abuse and alcoholism. Its general-director is Dr Rafael Velasco who is also secretary-general of the National Association of Universities and Higher Learning Institutes of Mexico.

There are no strings attached to the grant, and it may be extended for another year in March 1984, Dr Berruecos says. The donation should help the image of the brewers association, and this may prompt the distillers association to provide a similar grant, he adds.

There are an estimated eight million alcoholics in Mexico, although that figure may be low, Dr Berruecos says.

The CEPNEC would like to diminish the severity of alcohol problems throughout Mexico but believes the key to success is preventing the next generation of drinkers from acquiring bad habits, he says.

"We cannot offer many solutions to alcoholism," Dr Berruecos says, "but we can make people conscious of alcohol and its problems."

The CEPNEC wants to prepare information kits on alcohol use and abuse for teenagers and teachers and is planning some advertising and educational campaigns over the next year. The centre will use university facilities and resources throughout Mexico and can draw on graduating students who are required to work in community service programs to do some of the research and field work.

The CEPNEC is also planning a meeting later this year of international experts who will study the centre's approach and offer advice, Dr Berruecos says.

Berruecos: saving the next generation of drinkers

New anti-smuggling system speeds cargo examination

By Thomas Land

LONDON — A group of British companies has developed a new anti-smuggling examination system for container-cargo, designed specifically to identify contraband such as drugs, alcohol, and explosives.

The system enables customs authorities to examine rapidly cargo in standard containers or on pallets without unloading or unpacking them and without causing damage to them.

The system deploys x-ray and spectographic gas analysis, and the examination takes place while the cargo moves forward on conveyors.

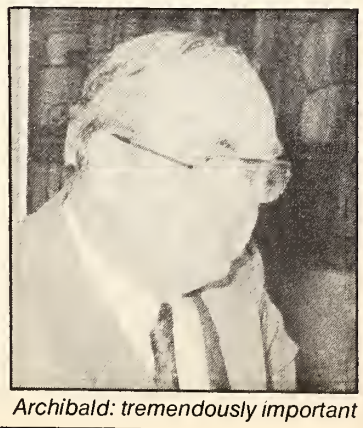
A spokesman for British Aerospace, the company which led the designers, explains: "Typically, 20 containers an hour may be examined, and this high throughput would be of immense value to port and customs authorities who at present must open every container for inspection — a process which may take one or two hours to complete."

The other companies associated in the venture are Taylor Woodrow, Rolls Royce, Radiation Dynamics, and Sciex.

ICAA gets $1M loan

TORONTO — The International Council on Alcohol and Addictions (ICAA) has received a $1 million loan from the Smithers Foundation of New York to help establish a capital fund.

H. David Archibald, ICAA president, says the loan is for a seven-year period and is "tremendously important" because the council's finances were in bad shape. Now, the first priority is to develop a pension program for the ICAA staff, Mr Archibald says.



Archibald: tremendously important

The ICAA, whose major objective is to "reduce and prevent the harmful effects of the use of alcohol and other drugs," will not have direct access to the loan. The money will be invested and the council will be able to draw on and/or reinvest the interest for the next seven years.

The Smithers Foundation is designed to make money available for work in the alcohol field and has made donations in the past to universities and treatment programs.

The Switzerland-based ICAA has official status with the United Nations as a non-governmental organization in the alcoholism and addictions field and also works closely with the World Health Organization and the International Labour Office. (See page 6.)

Responsibilty scale could help assess driver impairment

By Rhonda Birenbaum

OTTAWA — A psychologist has devised a system of assessing the responsibility of impaired drivers in causing traffic accidents, without the need for blood alcohol and drug level sampling.

Determining the degree to which drugs and/or alcohol are involved in specific traffic accidents poses a dilemma to Canadian researchers, policymakers, and police in light of a medico-legal limitation which prevents health care personnel from determining blood levels of drugs without the consent of the individual involved.

However, Kenneth W. Terhune, principle psychologist and automotive test engineer in the Accident Research Division of Calspan Field Services, Buffalo, NY, has developed a system of assessing liability without the need for drug exposure data.

He has devised a five-point "responsibility rating scale" whereby investigators can judge driver responsibility in various single- and multi-vehicle accidents independent of blood drug levels.

Based on police accident reports, the accident assessors place the driver on a continuum that ranges from "responsible" (the subject vehicle was the first to create the dangerous situation) through "contributory" (another vehicle or agent created the dangerous situation but the subject driver could have avoided the crash by a normal avoidance manoeuvre) to "neither responsible nor contributory" (the subject driver has no responsibility for the accident).

Dr Terhune tested the scale on more than 400 accidents for which blood alcohol and drug levels were known and found the responsibility rates generally increased systematically with the blood levels. That means "the responsibility ratings were sensitive enough to detect variations in impairment rates," he told the annual meeting of the American Association for Automotive Medicine here.

The proportion of drivers judged responsible increased from 44.9% in individuals with zero blood alcohol levels to 96.4% at levels of 0.2% (weight/volume) or more. At levels of 0.05% to 0.09%, 66.7% of drivers were responsible for the accidents. Of drivers with blood levels of 0.10% to 0.14%, 91.4% were responsible, and 76% were responsible if their blood alcohol levels were 0.15% to 0.19%, according to this study.

Dr Terhune said he used his scale to estimate the relative crash risk associated with blood alcohol content and plotted the curve of relative risk. This curve closely matched independent studies of accident risk relative to blood alcohol content.

The responsibility scale used was modified from a version used by researcher Kenneth Perchonok.

"We tried as much as possible to make our judgements (of accident responsibility) independent," Dr Terhune said. "Any mention in the police report of alcohol or drugs was obliterated so the coding would not be biased."

He said the responsibility scale may prove useful in assessing the role of drug use (other than alcohol) in traffic safety since no reliable method of measuring levels of such drugs exist for use in roadside tests. "We need to learn which drugs, if any, are impairing drivers and contributing to highway safety problems," Dr Terhune told **The Journal**.

In the absence of exposure data, responsibility ratings of accident drivers can help indicate drug impairment effects. "Drivers responsibility rates in crashes exhibited a positive relationship to blood (drug) levels, suggesting responsibility rates reflect impairment."

Teen driving course goes to younger viewers

By Mark Kearney

TORONTO — A driver education course designed for Ontario's high school students may prove more useful to elementary school children, says a government official.

Ed Blake, administrator of transportation safety with the ministry of transportation and communications, says there are plans to distribute the course materials, which deal with drinking and driving, to elementary schools for use in health classes.

The government-funded course, Three for the Road, may be more relevant at that level because it has been called "juvenile" by some high school students, Mr Blake told **The Journal**.

Students have criticized the course, which cost $450,000 to develop and distribute, for talking down to them, lacking some credibility, and having little shock value, he says. Some students also objected to the use of cartoon characters in the three films that are part of the course.

The films, Power Under Control, The Alcohol You, and No Thanks I'm Driving, have been distributed to school boards across the province for use by both secondary and elementary teachers. However, the teaching manual, which is provided for individual teachers, has to be translated into French before it is distributed in the elementary system, Mr Blake says.

Eileen Simon, PhD, a project manager for the course, says she was unaware it was to be distributed in elementary schools. She says, however, the response she received from high school students was favorable and enthusiastic.

Dr Simon says the course is more up to date than any other previous driver education material, more intensive on the topic of drinking and driving, and more thorough. It is also intended to provide students with behavioral "triggers" that constantly remind them to question their ability to drive safely.

The triggers are referred to as the "Can I/Am I" test. The students are reminded always to ask themselves before they get in the car "can I drive well and safely?" and, once they're driving, to ask "am I driving well and safely?"

Student driver course: am I driving well and safely?

Dr Simon says the course attempts to be "informative rather than patronizing and preaching."

Although the course was designed for high school students, it's flexible enough to be used by adults or any other new drivers, she adds.

Evelyn Vingilis, PhD, of the Addiction Research Foundation, also worked on developing the course and says pretesting showed it to be acceptable to older students.

Research suggests such a course is effective because it tries to relate the drinking and driving question to the individual, Dr Vingilis says.

Drug use declines slightly in Vancouver high schools

By Eleanor LeBourdais

VANCOUVER — The use of alcohol and drugs by city high school students here may be decreasing, says a British Columbia ministry of health survey.

The survey late last year polled approximately 10% of Vancouver's 17,000 students in grades 8 to 12 attending 18 city schools.

The 1982 study used random samples similar to four-year interval surveys conducted by the ministry in 1970, 1974, and 1978.

Questioned about alcohol and drug use in the preceding six months, respondents indicated an 18% reduction in alcohol consumption (to 69% in 1982 from 87% in 1978); marijuana use down 9% (to 39% in 1982 from 48% in 1978) and a 10% reduction in the number of students who smoke tobacco.

Responses also indicated an 8% increase in the use of solvents such as airplane glue, and inhalants such as amyl nitrite.

Use of cocaine was reported to be up 1% from 9% in 1978.

The overall 2% reduction in the reported use of alcohol and drugs since 1978 has been attributed to several possible causes. Researcher Marcus Hollander said renewed conservatism throughout society in general may have affected peer pressure, making drug use less "in," while reduced disposable income among adolescents, escalating illicit drug prices, and scarcity of supply resources may have also played their part.

Board of education chairman Kim Campbell said the drop in drug use could be a temporary phenomenon which might reverse itself when the economy improves.

Blood test refusal evidence of guilt rules US court

WASHINGTON — Refusal of a drunk driver to submit to a blood alcohol test if police think he or she is intoxicated can be disclosed at a trial as evidence of guilt, the United States Supreme Court has ruled. Most states do not compel a driver to take a blood alcohol test, but a driver who refuses generally faces loss of licence.

The court, in a seven-to-two decision, overturned a South Dakota court ruling that the introduction of refusal to submit to a blood alcohol test was equal to forcing a person to testify against himself. This, normally, is considered a violation of the fifth amendment to the constitution.

New York City sees rise in drug-related homicides

NEW YORK — Nearly a quarter of the homicides recorded in New York City in 1981 were drug-related, a police department study has revealed.

There were 393 drug-related slayings in a year when a total of 1,832 homicides were recorded, says the report. A total of 160 drug dealers were killed in robberies, with most other drug-related slayings arising from disputes about drugs.

While no comparable data for previous years were presented, Assistant Chief Anthony M. Voelker told the *New York Times* there had been a significant rise in drug-connected killings during the last 10 years.

Accident statistics 'amaze' researcher

Alcohol involved in most crashes

By Rhonda Birenbaum

OTTAWA — An overview of United States data shows that alcohol intoxication figures in almost two-thirds of fatal and injury-causing traffic accidents.

Speaking at the annual meeting of the American Association for Automotive Medicine here, James C. Fell of the US National Highway Traffic Safety Administration in Washington, presented statistics from two major US traffic accident data banks which "amazed" him.

"Alcohol was involved in about 55% of fatal accidents and 18% to 25% of injury-causing accidents," he said. That means more than 27,000 US citizens are killed in alcohol-related accidents per year (and more than 700,000 injured).

"Alcohol involvement," Mr Fell explains, refers to any measure of alcohol in the blood and/or any indication from police reports suggesting the driver was under the influence of alcohol.

In motorcycle driver deaths, Mr Fell found 43% of the drivers were legally intoxicated (legal in the state in which they were driving at the time of death) and 60% were driving with some level of alcohol in their blood, though not enough to be considered legally drunk.

He also says 44% of adult pedestrians killed on the road were under the influence of alcohol.

More drivers of the 22 to 24 years age group were killed while driving under the influence of alcohol than any other age group from 16 to 65 years, he said.

These statistics come from the Fatal Accident Reporting System, which lists all US fatal accidents since 1975, and the National Accident Sampling System, which details all reported traffic accidents (regardless of whether there was a fatality) since 1979.

Ontario ministry of transportation and communication statistics suggest approximately 30% of all fatal accidents involve drinking drivers.

US lifts ban on foreign aid for spraying of paraquat

WASHINGTON — The United States government, acting on an environmental impact study abroad by the state department, will now assist foreign governments that want to spray illegal drug crops with the herbicide paraquat.

A ban on US financial aid for such spraying was enacted by Congress in 1978 following reports illegally imported marijuana had been sprayed with the weed killer, and smokers might endanger their health. It was later decided there was only a very small health risk.

More than a year ago, the ban on foreign assistance for paraquat-spraying was lifted by Congress (**The Journal**, Apr, 1982), but the government did not resume foreign aid payments until completion of the state department's study.

NEWS

Society may have to re-examine social drinking

By Ken Zeilig

LOS ANGELES — A study here on the effects of social drinking shows an important and significant correlationship between the way the brain works (cognitive capacity) and the amount of alcohol a person drinks.

The more a person drinks the more there is cognitive dysfunction, says Ernest P. Noble, PhD, MD, Pike Professor of alcohol studies, University of California at Los Angeles, and director, UCLA Alcohol Research Center.

"If you're a professor you need to sit down and prepare lectures, write papers, etc; if you're in the business world you need to have your brain working 100% to strike a good deal," he told a symposium here on the psychobiology of alcoholism.

"Most people have ignored the fact. They go and make their deals while they're drinking heavily and saying, 'As long as I'm not an alcoholic I don't have to worry about the drinking.' Well, these studies — and others around the country which are now coming out — are beginning to raise serious questions whether drinking of that nature is innocuous to brain function."

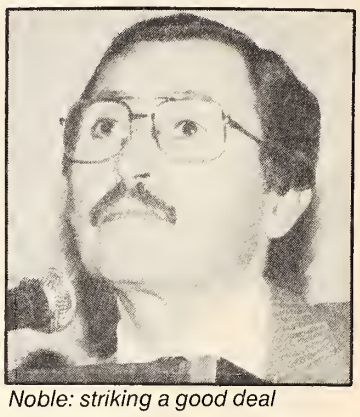
They show that in men and women and people of different ethnic backgrounds and in different age groups, social drinking seems to be correlated with negative cognitive performance.

Dr Noble used the Halstead Category Test, the Shipley-Hartford Institute of Living Scale, and the Wisconsin Card Sorting Test to determine cognitive dysfunction.

Tests were done on people who were social drinkers, average age 42 years, and who were functioning well in society, he says.

Another study was done on 22-year-old men who drank a little more but less frequently, and " the findings were the same; namely, that the amount they drank proportionately, significantly correlated with decreases or decrements in their cognitive functioning." Studies in other areas support the findings.

Dr Noble stresses his study was correlational and further studies are needed to determine if there is a cause and effect relation between drinking and cognitive performance. If so, society may have to re-examine its approach to social drinking, he adds.



Noble: striking a good deal

Nevertheless, his study "will help us to understand what the dynamics are and maybe set up preventative strategies in heavy drinkers to prevent them from getting into alcohol-induced harm."

The next step? "We want to see what happens when social drinkers cut down their drinking. Does cognitive function improve? We want to see what the sub-population of so-called social drinkers are like? Is it an inherited tendency for social dysfunction? I think we need to begin to study that," Dr Noble said.

First offenders jailed 72 hours

Ohio toughens drunk driving laws

CINCINNATI — Ohio's tough new drinking and driving law should generate more money for alcohol treatment programs but may create overcrowding in state jails, health officials say.

The law, in effect since March 16, sets 0.10% as the blood alcohol level at which a driver is automatically guilty of impaired driving, calls for a mandatory jail sentence of 72 consecutive hours for a first offence, and requires people who have their licence suspended for impaired driving to pay a $75 reinstatement fee. The money will go to state driver treatment and intervention programs.

Brian Mahoney, of the state's department of health, says the new law is "a step forward." However, officials may be reluctant to enforce it because of possible overcrowding in jails and the increased penalties on conviction, he says.

Under previous law, offenders were jailed for three days. The change to 72 hours prevents their going in just for the weekend, he says.

Howard Rahtz, executive director of the Alcoholism Council of Cincinnati, agrees a stronger law was needed and doesn't believe it will be under-enforced. The 0.10% level "is pretty straightforward" and won't, as some officials fear, necessarily lead to more jury trials, he told **The Journal**.

Mr Rahtz says health officials should know in a few months how much money is being directed to treatment programs because of the new law.

Ohio is also considering including a two-cent per drink tax on alcoholic beverages that could generate $96.1 million annually. The money would support alcohol and drug abuse services and provide budgetary help for local governments in related areas, Mr Rahtz says.

US railroad workers face tight new alc/drug rules

WASHINGTON — Rules to control drug and alcohol use among employees on United States railroads are now under consideration by the government.

Until now, railroads have had their own prohibitions against drinking while on duty or on call, but these proposals are the first by the government concerning drug and alcohol use on the railroad.

The US federal railroad administration is considering requiring a trained crew member to certify he and other crew members are not under the influence of drugs or alcohol when they take control of the train.

In addition, the national transportation safety board believes railroad safety would be improved if employees knew they would be screened for alcohol and drug use following a serious accident.

Transportation secretary Elizabeth Dole said the problem deserves immediate attention and she favors "a consensual approach" by management and labor.

Few qualify for grants

States missing DWI target

WASHINGTON — A financial carrot to get individual states to toughen up their drunk-driving laws seems to have criteria so difficult that few, if any, could qualify at the moment.

The United States department of transportation's National Highway Traffic Safety Administration has set up strict rules for states to share in a $125-million payout during the next three years. Between $250,000 and $1 million would be given to each state, based on the number of drivers and miles of road in each.

The states would have to specify that a driver found with a 0.10% blood alcohol level be considered drunk; automatically revoke for 90 days the licence of a first offender, and one year for a second offender; sentence second offenders to at least 48 hours in jail or 10 days community service; and demonstrate stepped-up law enforcement.

Some state officials said the proposals were so tough that no state could meet them at present.

Iowa suggests alcohol user tax

DES MOINES — The Iowa Commission on Substance Abuse wants an additional user tax on alcoholic beverages to help pay for substance abuse prevention and treatment services here.

The commission believes such a fee will help communities combat alcoholism (the third major health problem in Iowa) and drug addiction. The estimated annual cost to Iowans for alcohol-related programs is $273 million.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

Doin' What the Crowd Does

Number: 547.
Subject heading: Attitudes and values, trigger films, youth and drugs.
Details: 5 min, 16mm, color.
Synopsis: While singing and dancing, a group of young people are shown doing what they like to do (eg, skipping and other physical activity). In the background other young people tempt them to drink, smoke marijuana, and pop pills.
General evaluation: Good (4.3). This contemporary, well-produced film is a good discussion starter.
Recommended use: With a resource person to lead the discussion, this film could benefit audiences of eight to 18 years.

Deciso 3000

Number: 548.
Subject heading: Attitudes and values, drugs and youth, trigger films.
Details: 5 min, 16mm, color.
Synopsis: Deciso is a planet with two-headed people. One young person, on the way to meet a girl at a movie, pops a pill. He then tries to get her to take one too and while one of her heads says yes, the other says no. Finally the "no" head prevails and the young man flies off.
General evaluation: Good (4.4). This contemporary, well-produced film is likely to produce attitudes opposed to drug abuse.
Recommended use: With a resource person to lead the discussion this film could benefit audiences of eight to 14 years.

Jojo's Blues

Number: 549.
Subject heading: Attitudes and values, trigger films.
Details: 5 min, 16 mm, color.
Synopsis: A new boy moves into the neighborhood and wants to join the local boys gang. His initiation is to ride up in an elevator on a construction site. His two "friends" will then get him to jump to another passing elevator. Unfortunately, the elevators break down and the boys escape just before it crashes. They have to walk along girders to climb down.
General evaluation: Good to very good (4.7). This contemporary, well-produced film could be a good discussion starter about risk-taking behaviors.
Recommended use: With a resource person to lead the discussion, this film could benefit audiences of eight to 14 years.

Medical Aspects of Alcohol and other Drugs of Abuse

Number: 550.
Subject heading: Alcohol and alcoholism overview, alcohol-pharmacology, drugs-pharmacology.
Details: 58 min, 16 mm, color.
Synopsis: The effects of alcohol and other drugs on the body and its organs are demonstrated through illustrations.
General evaluation: Poor (2.1). This film was judged a poor teaching aid because of reservations about accuracy. It was also judged to be too long and boring.
Recommended use: None.

Getting Straight

Number: 551.
Subject heading: Drugs and youth, treatment/rehabilitation.
Details: 23 min, video cassette, color.
Synopsis: Getting Straight Inc is a drug treatment program in Florida. Young people are brought by their parents, by police, or come in by themselves. All have been heavy drug users. They are totally controlled in their first weeks until they prove they can be trusted. They must attend group sessions and confess that drugs are their problem. They see their parents only at mass meetings, which the parents must attend.
General evaluation: Fair (3.4). This tape was considered a poorly produced public relations film. Although it evoked emotion it was not judged to be a good teaching aid.
Recommended use: For parents looking for a place to send their drug-using children.

Sexuality: Alcohol and Drugs

Number: 552.
Subject heading: Attitudes and values, alcohol and sex.
Details: 28 min, 16 mm, color.
Synopsis: The film defines sexuality as the thoughts we have about ourselves. Many people use drugs to relieve the guilt and fear they have about themselves and their interactions with people of the opposite sex. They become psychologically addicted and use the drugs to enable them to do what they could not do otherwise. They may become chemically dependent and have even more problems.
General evaluation: Very poor (1.3). This film was judged a poor teaching aid, boring, and out of date.
Recommended use: None.

Family Violence: Conspiracy of Silence

Number: 553.
Subject heading: Alcohol and the family, women and alcohol.
Details: 26 min, video cassette, color.
Synopsis: Violence is everywhere says Julie Harris who narrates this documentary about the effects of violence on several people. Many women abuse alcohol and other drugs and are also abused by their husbands who drink excessively. Most of the violence in the family is against women, and there is a growing link between this and alcoholism and drug abuse. Women are urged to get help.
General evaluation: Good (4.2). This contemporary film was judged a good teaching aid.
Recommended use: General audiences and battered wives could benefit.

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DEPARTMENT

New Books by RON HALL

Drugs and Drug Abuse: A Reference Text

. . . by Terrence C. Cox, Michael R. Jacobs, Eugene A. LeBlanc, and Joan Marshman

Pharmacology is the main focus of this book; however, psychology, medicine, chemistry, epidemiology, and a number of other disciplines are represented. The introductory chapter is a general outline and exploration of the basic issues involved in drug use, drug abuse, and drug dependence. Following the overview chapter on drug use are chapters on the various classes of psychoactive drugs: central nervous system depressants, hallucinogens, mood modifiers, narcotic analgesics, and stimulants. Each of these chapters provides extensive information about one specific class. The psychoactive drugs selected for inclusion in the third section are those that have the greatest popularity in North American society today. The drugs described in the briefer articles in the fourth section are generally of less importance in the overall context of abuse than those in the previous section. Drugs found in the fifth section attract limited attention, but may come to the attention of health and legal professionals from time to time. The final section offers a comprehensive listing of the Canadian and US trade names for most of the legitimately-marketed psychoactive drugs discussed in the book, as well as a medical/scientific glossary, a glossary of street drug language, and a subject index.

(Addiction Research Foundation, Marketing Services, 33 Russell St, Toronto, ON M5S 2S1. 1983. 583 p. $29.50. ISBN-0-88868-073-2)

Residential Home Management

. . . by Richard Solomon and Linda Lerner Solomon

This handbook for managers of community-living facilities is designed to help with the increased responsibilities and complexities that will ensue. The authors emphasize an awareness of process by showing the experiences of manager and resident in a facility from their own perspectives. The reader is provided with concrete strategies, based upon well-established psychological principles, for coping with unexpected or difficult situations and ways of significantly reducing many of the personal stresses inherent in this occupation. The authors cover the range of managerial experience, including the initial contact, the methods required to stimulate growth and development of residents, and strategies that may be used to overcome community resistance.

(Human Sciences Press, 72 Fifth Ave, New York, NY 10011. 1982. 144 p. $19.95. ISBN 0-89885-037-1)

Social Groupwork and Alcoholism

. . . edited by Marjorie Altman and Ruth Crocker

The focus is on the variety of groups that aid, by interpersonal means, the alcoholic to achieve sobriety and return to health. One paper describes a five-phase group curriculum for outpatient treatment. It addresses the changing needs of the alcoholic from active drinking through one year of sobriety by viewing the recovery process as a continuum. Another paper describes the SOBER program, a stress management program for recovering alcoholics. Assertiveness is presented as a model of intervention with alcoholics and others during the recovery phase of alcoholism. Other articles deal with a short-term group treatment model for problem-drinking drivers; spouse participation in the treatment of alcoholism; a short-term family group for relatives of alcoholics; a pre-group experience for women in recovery from alcoholism and other addictions; group treatment of children from alcoholic families; alcoholism treatment for the deaf; and group treatment for elderly alcoholics and their families.

(Haworth Press, 28 E 22nd St, New York, NY 10010, 1982. 104 p. $16. ISBN 0-917724-94-1)

Other Books

Alcohol and Disease — Sherlock, Sheila (ed). Churchill Livingstone, London, 1982. Epidemiology of alcohol use; economic aspects; metabolism; nutrition; cancer; endocrine system; sex, alcohol and the developing fetus; muscle disease; pancreas; alcoholic liver disease; gastrointestinal tract; heart; brain damage; psychological changes after alcohol withdrawal; treatment. Index. 116 p. Academic Press Canada, 55 Barber Greene Rd, Don Mills, ON M3C 2A1. $26. ISBN 0-443-02532-0.

All About Drinking — Foster, Fiona and Smith, Alexander McCall. Macdonald Publishers, Edinburgh, 1981. Intended for older children and young adolescents; types of alcohol; effects on the body; behavioral effects; causes of drinking; social problems; harmful effects. 47 p. Bookstore, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1. $6.50. ISBN 0-904265-62-8.

Alcohol and Reproduction: A Bibliography — Abel, Ernest L. Greenwood Press, Westport, 1982. 2,120 citations dealing with sexual behavior, sexual function, and sexual physiology; fetal alcohol syndrome. Index. 219 p. Greenwood Press, PO Box 5007, 88 Post Rd W, Westport, CT 06881. $29.95. ISBN 0-313-23474-4.

Going Home: A Re-entry Guide for the Newly Sober — Woititz, Janet Geringer. CompCare Publications, Minneapolis, 1981. Booklet designed to ease re-entry. 39 p. CompCare Publications, 2415 Annapolis Ln, Ste 140, Minneapolis, MN 55441. $2.25. ISBN 0-89638-049-1.

Proceedings of the 1979 Summer School on Alcohol and Addiction Studies — Wasserman, Paul Z. and Segal, Bernard (eds). Center for Alcohol and Addiction Studies, Anchorage, 1979. Alcoholism in the '80s; classic and contemporary views of alcoholism; prevention; perspectives on drinking in Alaska; women and alcohol; drug use and youth. 242 p. Center for Alcohol and Addiction Studies, University of Alaska, 3211 Providence Dr, Anchorage, AL 99504. $12.

Proceedings of the 1981 Annual School on Alcohol and Addiction Studies — Oglietti, Janice R. and Segal, Bernard (eds). Center for Alcohol and Addiction Studies, Anchorage, 1981. Traditional healing methods; effective treatment; chemicals and youth; diagnostic concepts; family conflict and therapy; marijuana; matching client needs and treatment methods. 345 p. Center for Alcohol and Addiction Studies, University of Alaska, 3211 Providence Dr, Anchorage, AL 99504. $12.

Preventing Drug Abuse at Work: A Manual for Professionals — Webb, C. William. Charlotte Drug Education Center, Charlotte, 1980. Identifying clients; diagnosis; design; communications module; coping with stress; drug information/corporate policy module; group problem-solving and decision-making; leadership; performance appraisal. References. 289 p. Charlotte Drug Education Center, 1416 E Morehead St. Charlotte, NC 28204.

Behavioral Pharmacology of Human Drug Dependence — Thompson, Travis and Johanson, Chris E. (eds). US Government Printing Office, Washington, 1981. National Institute on Drug Abuse Monograph No 37; historical and personality factors; stimulus control and drug dependence; commonalities and differences among reinforcers. 294 p. US Government Printing Office, Washington, DC 20402. $6.50 S/N 017-024-01109-6

Alcohol and Youth: A Comprehensive Bibliography — Barnes, Grace M. Greenwood Press, Westport, 1982. 4,666 citations related to alcohol and youth. Index. 452 p. Greenwood Press, 88 Post Rd W, PO Box 5007, Westport, CT 06881. $45. ISBN 0-313-23136-2

Steering Clear: Helping Your Child Through the High-Risk Drug Years — Cretcher, Dorothy. Winston Press, Minneapolis, 1982. Young people and drugs; alcohol and tobacco; marijuana; other drugs; prevention; dealing with the drug use of your child. 112 p. Winston Press, 430 Oak Grove, Minneapolis, MN 55403. ISBN 0-86683-689-6

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

3rd Mental Health and Deafness Conference: Focus on Assessment and Treatment — May 26-27, Toronto, Ontario. Information: Conference Coordinator, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

International Conference on Prison Abolition — May 26-28, Toronto, Ontario. Information: International Conference on Prison Abolition, c/o QCJJ, 60 Lowther Ave, Toronto, ON M5R 1C7.

Medic Canada '83 . . . Toward the Year 2000 — May 29-31, Edmonton Alberta. Information: Toby Fay Sykes, Medic Canada '83, 480 Garyray Dr, Toronto, Ontario M9L 1P8.

Canadian Guidance and Counselling Association 9th Biennial Conference — May 31-June 3, Fredericton, New Brunswick. Information: Richard Harvey, Conference Chairman, CGCA '83, Fredericton, NB E3B 5G4.

Update: Current Issues In Psychiatric Nursing — June 6, Toronto, Ontario. Information: Evon Essue, Conference secretary, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Detox Training Program (Non-Medical) — June 6-10, Toronto, Ontario. Information: Gord Gooding, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

3rd Annual Summer School on Addictions — June 19-24, Charlottetown, Prince Edward Island. Information: Department of extension and summer sessions, University of Prince Edward Island, Charlottetown, PEI C1A 4P3.

Canadian Association of Health, Physical Education and Recreation 50th Anniversary Conference — June 26-29, Toronto, Ontario. Information: Russ Kisby, c/o Participaction, 80 Richmond St W, Ste 805, Toronto, ON M5A 2A4.

Cannabis Consequences for Canadians — June 28, Toronto, Ontario. Information: George W. Peck, vice-principal, Sir William Osler Vocational School, 1050 Huntingwood Dr, Agincourt, ON M1S 3H5.

Canada Safety Council 15th Annual Safety Conference — June 26-29, Moncton, New Brunswick. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, Ontario K1G 3V4.

5th World Conference on Smoking and Health — July 10-15, Winnipeg, Manitoba. Information: Kurt Baumgartner, Box 8159, Terminal PO, Ottawa, Ontario K1A 0C1.

24th Annual Institute on Addiction Studies — July 17-22, Hamilton, Ontario. Information: Alcohol and Drug Concerns Inc, 15 Gervais Dr, Ste 603, Don Mills, ON M3C 1Y8.

Summer Course in Addictions (Fundamental Concepts) — July 18-21, Toronto, Ontario. Information: Barbara MacPherson, Administrative Coordinator, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

International Doctors in Alcoholics Anonymous Annual Meeting —Aug 4-7, Vancouver, British Columbia. Information: Lewis Reed MD, IDAA Secretary, 1950 Volney Rd, Youngstown, Ohio 44511.

2nd World Congress on Prison Health Care — Aug 28-31, Ottawa, Ontario. Information: Congress Secretariat, Medical Services Branch, The Correctional Service of Canada, Ottawa, ON K1A 0P9.

Royal College of Physicians and Surgeons Annual Meeting — Sept 19-22, Calgary, Alberta. Information: Robert A. Davis, associate director, Office of Fellowship Affairs, Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

1984 Canadian Addictions Foundation Atlantic Regional Conference — April 29 - May 3, 1984, Halifax, Nova Scotia. Information: Nova Scotia Commission on Drug Dependency, 5668 South St, Halifax, NS B3J 1A6.

United States

Family Program For Professionals — May 16-20, Aug 15-19, Sept 19-23, Oct 17-21, Nov 28-Dec 2, Center City, Minnesota. Information: Marilyn Brissett, continuing education department, Hazelden Foundation, Center City, MN 55012.

3rd Annual National Conference for Nurse Educators on Current Issues in Alcohol and Drug Abuse: Research, Education, and Clinical Practice — May 18-20, Washington, DC. Information: Geral Dene M. Burdman, PhD, Alcohol and Drug Abuse Nursing, SC-78, School of Nursing, University of Washington, Seattle, Washington 98195.

5th Annual School on Alcoholism for Physicians and Related Health Professionals — May 19-21, New York, NY. Information: NYU Post-Graduate Medical School, 550 First Ave, New York, NY 10016.

Scientific and Regulatory Aspects of Bioavailability of Drugs and Pharmacokinetics — May 23-25, East Brunswick, New Jersey. Information: General Information, PO Box H, East Brunswick, NJ 08816-0257.

2nd Annual Conference on Alcoholism and the Family — May 25-29, Philadelphia, Pennsylvania. Information: Richard W. Esterly, chairman, National Conference on Alcoholism and the Family, Box 277, Wernersville, PA 19565.

Drinking and Driving Symposium — May 31, Detroit, Michigan. Information: James Schaefer, director, Office of Alcohol and Other Drug Abuse Programming, Rm 360, 2610 University Ave, St Paul, Minnesota 55114.

Introduction to Pharmacology — June 1-3, East Brunswick, New Jersey. Information: General Information, PO Box H, East Brunswick, NJ 08816-0257.

Pulling Together — The Many Issues of Ethical Principles — June 5-7, Traverse City, Michigan. Information: Sally Myers, MAAA, 29563 Northwestern Hwy, Ste 7, Bldg F, Southfield, MI 48034.

The Mid-South Summer School on Alcohol and Drug Problems — Prevention and Treatment — June 5-10, Fayetteville, Arkansas. Information: Gwen Briscoe, GSSW-UALR, Little Rock, AR 72204.

International Summer School on Counselling the Family of the Chemically Dependent — June 6-9, Moorhead, Minnesota. Information: Debby Thornton, CD School Secretary, department of social work, Moorhead State University, Moorhead, MN 56560.

4th Annual National Conference on Employee Assistance Programming — June 6-9, Kansas City, Kansas. Information: The EAP Conference Center, Bethany Medical Center, 51 North 12th St, Kansas City, KS 66102.

Seminar on Chemical Dependency and Adolescents — June 6-10, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

Alcohol/Drug Dependency and Mental Illness — June 7-8, Oct 11-12, Center City, Minnesota. Information: Marilyn Brissett, continuing education department, Hazelden Foundation, Center City, MN 55012.

Employee Assistance Programming for the Eighties: A Shared Responsibility — June 9-10, Covington, Louisiana. Information: Bowling Green Foundation, PO Box 417, Mandeville, LA 70448.

10th Annual South Carolina School of Alcohol and Drug Studies —June 12-17, Rock Hill, South Carolina. Information: Julie Trent, SCCADA, 3700 Forest Dr, Columbia, SC 29204.

45th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 13-15, Lexington, Kentucky. Information: Dr Joseph Cochin, Executive secretary, Boston University School of Medicine, 80 Concord St, Boston, Massachusetts 02118.

Training School on Alcohol and Drug Abuse — June 13-July 1, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

The ABC's of The Church and Alcohol — June 14-17, Byfield, Massachusetts. Information: North Conway Institute, 14 Beacon St, Boston, MA 02108.

Summer School of Alcohol Studies — June 19-July 8, New Brunswick, New Jersey. Information: Gail Gleason Milgram, education and training division, Center of Alcohol Studies, Smithers Hall, Rutgers University, New Brunswick, NJ 08903.

University of Utah School of Alcoholism and Other Drug Dependencies — June 19-24, Salt Lake City, Utah. Information: University of Utah School on Alcoholism and Other Drug Dependencies, PO Box 2604, Salt Lake City, UT 84110.

34th Annual Symposium on Alcoholism — Alcoholism and the Family — June 20-July 1, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, Seattle, WA 98122.

Alcoholism in the Workplace — June 21-23, Boston, Massachusetts. Information: Office of Continuing Education, Harvard School of Public Health, 677 Huntington Ave, Boston, MA 02115.

12th Annual San Diego Summer Alcohol and Drug Studies Program — July 10-15, San Diego, California. Information: UCSD Extension, X-001, University of California, San Diego, La Jolla, CA 92093.

Chemical Dependency and Family Intimacy — July 17-22, Marine-on-St Croix, Minnesota. Information: Coordinator, CDFI Summer Institute, Program on Human Sexuality, University of Minnesota, 2630 University Ave SE, Minneapolis, MN 55414.

World Congress on Mental Health — July 22-28, Washington, DC. Information: World Federation for Mental Health, #107-2352 Health Sciences Mall, University of British Columbia, Vancouver, BC V6T 1W5.

New Jersey Summer School of Alcohol and Drug Abuse Studies — July 31-Aug 5, New Brunswick, New Jersey. Information: Gail Gleason Milgram, education and training division, Center of Alcohol Studies, Smithers Hall, Rutgers University, New Brunswick, NJ 08903.

12th Annual Southern Oregon Institute of Alcohol Studies — July 31-Aug 5, Salem, Oregon. Information: Ruthanne Lidman, SOIAS, 4540 Liberty Road South, Salem, OR 97302.

4th Annual Illinois Institute on Drug Abuse — Aug 1-4, Bloomington, Illinois. Information: Louis DiFonso, Illinois Dangerous Drugs Commission, 300 State St, Ste 1500, Chicago, IL 60610.

National Association of Alcoholism and Drug Abuse Counselors (NAADAC) Conference — Aug 7-10, Houston, Texas. Information: David W. Oughton, National Association of Alcoholism and Drug Abuse Counselors, 951 South George Mason Dr, Ste 204, Arlington, Virginia 22204.

Prevention-Outlook for the '80s — Aug 18-20, Myrtle Beach, South Carolina. Information: Cathy McKinney, Charlotte Drug Education Center, 1416 E Morehead St, Charlotte, North Carolina 28204.

Alcohol and Drug Problems Association of North America 34th Annual Meeting — Aug 28-Sept 1, Washington, DC. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

7th Annual Summer Institute on Drug Dependence — Aug 28-Sept 2, Colorado Springs, Colorado. Information: Dan Barmettler, Institute for Integral Development, PO Box 2172, Colorado Springs, CO 80901.

Drug and Alcohol Issues Symposium — Sept 14-16, Dayton, Ohio. Information: Thomas Prugh, WORAC, 379 W First St, Ste 300, Dayton, OH 45402.

2nd Annual Conference of the National Federation of Parents for Drug-Free Youth — Sept 26-28, Washington, DC. Information: National Federation of Parents for Drug-Free Youth, 1820 Franwall Ave, Ste 16, Silver Spring, Maryland 20902.

American Association for the Study of Liver Diseases — Nov 4-7, Chicago, Illinois. Information: C. B. Slack, 6900 Gorve Rd, Thorofare, New Jersey 08086.

American Society of Criminology 35th Annual Meeting — Nov 9-12, Denver, Colorado. Information: Joseph E. Scott, department of sociology, Ohio State University, Columbus, Ohio 43210.

1983 Western Regional Conference — Nov 13-16, Los Angeles, California. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

Abroad

2nd European Symposium of Acupuncture — June 3-5, Stockholm, Sweden. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

29th International Institute on the Prevention and Treatment of Alcoholism — June 27-July 2, Zagreb, Yugoslavia. Information: Archer Tongue, International Council on Alcohol and Addictions, Case postale 140, 1001 Lausanne, Switzerland.

9th International Conference of the International Association for Accident and Traffic Medicine — July 10-15, Mexico. Information: Dr R. Andreasson, IAATM, PO Box 10043, 5-100 55 Stockholm 10, Sweden.

8th Institute on Drugs, Crime, and Justice in England and America — July 11-15, London, England. Information: Institute on Drugs, Crime and Justice, School of Justice, The American University, Washington, DC 20016.

7th World Congress of Psychiatry — July 11-16, 1983, Vienna, Austria. Information: Congress Team International, PO Box 9, A-1095 Vienna.

Australian Medical Society on Alcohol and Drug Related Problems 3rd Annual Conference —July 31-Aug 7, Cairns, North Queensland, Australia. Information: Conference Organizers, PO Box 155, Civic Square, ACT, 2608, Australia.

Middle Eastern Summer Institute on Drug Use (MESIDU): Techniques, Strategies, Concepts, and Options — Sept, Jerusalem, Israel. Information: Stan Einstein, PhD, Director, MESIDU, 113/41 East Talpiot, Jerusalem, Israel.

International Conference on Alcoholism — Sept 26-30, Reykjavik, Iceland. Information: ICAA, Case postale 140, 1001 Lausanne, Switzerland.

13th International Institute on the Prevention and Treatment of Drug Dependence — Oct 10-14, Oslo, Norway. Information: ICAA, Case postale 140, 1001 Lausanne, Switzerland.

8th World Congress of Acupuncture — Oct 12-16, Seoul, Korea. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

9th International Conference on Alcohol, Drugs and Traffic Safety — Nov 13-18, San Juan, Puerto Rico. Information: T-83 Secretariat, GPO Box 5067, Medical Sciences Campus, San Juan, Puerto Rico 00936.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

2nd International Congress on Drugs and Alcohol — Dec 18-22, Tel Aviv, Israel. Information: Congress Secretariat: Peltours Ltd, Congress department, PO Box 394, Tel Aviv, 61003 Israel.

4th World Congress of Alternative Medicine — July 13-15, 1984, Amsterdam, Netherlands. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

Experts ponder state of 'no play'

UK alcohol field in policies war

By Alan Massam

LONDON — The rumbling of discontent against the British government's refusal to deal adequately with the rising tide of alcoholism here is fast becoming a roar of disgust.

Prime Minister Margaret Thatcher represents a political philosophy with which most British doctors sympathize, so an all-out attack on Conservative government policy by the *British Medical Journal*, the official journal of the British Medical Association (BMA), can be considered something of an event.

Just such an attack appeared in the editorial column after Parliamentary Secretary for Health Geoffrey Finsberg came to the BMA House to address a symposium sponsored by the Medical Council on Alcoholism and the Scotch Whisky Association.

A "Who's Who" in alcoholism turned out, and many of the assembled experts hoped for a government commitment to treatment and rehabilitation appropriate to the size of the problem.

But they were disappointed.

Mr Finsberg repeated an earlier statement that "the key to preventing misuse is for individuals to recognize and accept responsibility for their own health.

"Whatever the government and other agencies may do," he declared, "controls must be applied by individuals themselves."

For a government reportedly dedicated to the principle of prevention, Mr Finsberg's dismissal of scientific opinion was something of a political raspberry which must have reverberated down many a stethoscope.

And the *British Medical Journal* rose to the challenge.

Under the headline "Absence of alcohol policy" it pointed out that Mr Finsberg spoke only for the department of health and social security (DHSS), but 16 government departments had an interest in alcohol.

"Many of these departments — for instance the Treasury — are much higher in the departmental pecking order than the DHSS, and some of these departments — for instance the department of employment and the board of trade — are more interested in jobs and profits than in the nation's health," the editorial observed.

"The DHSS is left with few resources and little goodwill to cope with the problems that result from Britain drinking twice as much as it did two decades ago."

The irony of the present state of no-play on alcohol abuse is that the government's Think Tank — The Central Policy Review Staff (CPRS) — produced a confidential report on alcohol policies in the UK in 1979.

Bruun: short-sighted strategy and a blow to intellectual tradition in Britain

The leaked report concluded, according to the *British Journal of Addiction*, (June, 1982), that there should be a positive government commitment on countering difficulties and that the trends toward making drink cheaper as a result of the lag of revenue duties should be arrested.

This report has never been published to allow public debate in Parliament and must by now be the most widely-leaked secret document ever produced. (See —Gilbert — p 5)

Last year comment on it was so widespread that Professor Kettil Bruun had a copy reproduced and offered it for sale for $4 in Stockholm. Sales are going well, in spite of government attempts to suppress the report under the British Official Secrets Act.

At the Medical Council on Alcoholism Conference in BMA House, Mr Finsberg said of the document: "Some of you may ask why the government did not publish the CPRS report commissioned by its predecessor (the previous Labour administration). To this I must reply that most reports by the CPRS are intended as confidential advice to (cabinet) ministers and as such are not published."

The *British Medical Journal* commented: "The government's strategy is in essence to turn alcohol problems from a public health issue into a problem for individuals. Professor Bruun (who attended the meeting at the BMA House) pointed out that this strategy was being adopted in many countries; he thought it was a short-sighted strategy and said that 'it would be a blow to the intellectual tradition in the UK,' if this redefinition of alcohol problems as primarily a concern for individuals was not challenged.

"Mr Finsberg went on to say that 'Our immediate . . . objective must be to inform and encourage public debate.' Nevertheless, refusing to publish the Central Policy Review Staff's report . . . seems a very poor start for such a policy."

Even in economic terms, this will surely prove to be a short-sighted policy in the long run.

As a nation Britain spends more on alcohol than on fuel and light (£4,937 million in 1977 — Cdn $9.6 billion); much more than on newspapers, cigarettes, books, or other forms of entertainment, and nearly as much as on clothing and footwear.

In the years between 1966 and 1977 the number of people found guilty of drunkenness or drunk driving increased to 144,000 from 74,000 and, in the last 20 years, National Health Service admissions to psychiatric hospitals for alcoholism treatment have increased 25-fold.

The estimated cost to the nation of production lost because of alcohol misuse was about £350,000,000 in 1977 and, when added to the cost of accidents, fires, and damage to property, was about £1,000 million (Cdn $1.95 billion).

The tax revenue on alcohol products annually in Britain is estimated to be £3,597 million.

What then will the British government do about alcohol problems? The answer came recently when Home Office Minister David Mellor launched a campaign promoted by the Brewers' Society to combat under-age drinking.

It consists of a set of posters for display in pubs reminding customers that alcoholic drinks may not be bought or consumed in bars by anyone under 18 years and some "notes for the guidance of licensees and staff concerning children and young people."

Mr Mellor, who was undertaking his first public engagement as junior minister at the Home Office, said it would be irresponsible for the government to take any initiative in relaxing the licensing laws in isolation from the wider issues and without regard to the government's general strategy for helping prevent alcohol misuse.

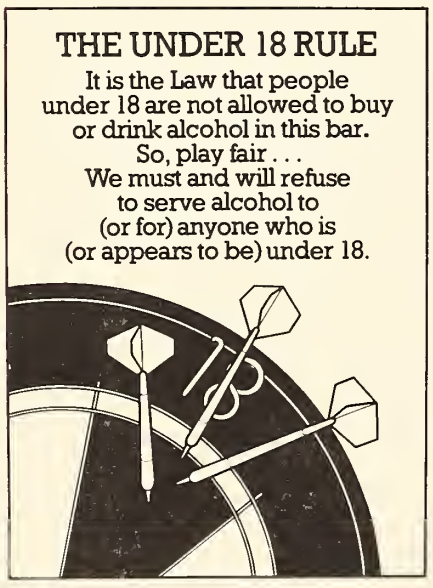
"Of those at risk, young people are perhaps the most vulnerable," he said. "The present 18-year limit was introduced in 1923 and is based on the belief that they should not be exposed, on their own, to the risks of alcohol misuse until they are old enough to recognize its potency and to use it wisely.

"Although there are some who say that because young people now mature earlier the drinking age should be lowered, I believe they are wrong," Mr Mellor said.

It's unlikely the medical and social service workers trying to deal with alcohol misuse will be enthusiastic about the Home Office's modest contribution. As the *British Journal of Addiction* said last year in an editorial headlined "Cirrhosis as a growth investment opportunity" . . . "alcohol problems and cigarette smoking constitute public health issues as important as such classical battle grounds as adequate drainage, clean water and clean air, meat inspection or getting tubercle bacilli out of the milk supply.

"We must be willing to fight our latter-day battles with vigor . . . against the handicap of a government which is willing to trade the nation's health for profit and expedience."

Thatcher: a political raspberry reverberating down many a stethoscope



Poster: a 'modest contribution'

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The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

The perils of real-world alcoholism research p 9

Pendery uneasy about participating

Second US review of Sobell work underway

By Karin Maltby

TORONTO — A United States government investigation into allegations of scientific misconduct by two alcoholism researchers may be jeopardized because the key complainant is hesitant about cooperating.

Psychologist Mary Pendery, PhD, has withheld data from two previous investigations. Her data purport to contradict favorable results reported by psychologists Mark and Linda Sobell, PhDs, in their early-1970s work on controlled-drinking training for *gamma* (physically-dependent) alcoholics.

Dr Pendery, a psychologist with the Veterans Administration Medical Center in San Diego, CA, is first author of the article, Controlled Drinking By Alcoholics? New Findings and a Re-evaluation of a Major Affirmative Study, which was published in *Science* (July, 1982).

At the April meeting in Houston of the US National Council on Alcoholism, Dr Pendery said she had reservations about participating in a review by the US Alcohol, Drug Abuse and Mental Health Administration (ADAMHA).

Mildred Lehman, Office of Public Affairs at the ADAMHA, told **The Journal** Dr Pendery's information is "absolutely essential to establish the direction of the investigation."

She said Dr Pendery, and second and third authors of the Science article, Irving Maltzman, PhD, and L. Jolyon West, MD, have been invited to meet with the ADAMHA review group.


Mary Pendery

At the Houston meeting, however, Dr Pendery said: "The problem with an investigation (by the ADAMHA) is that they have no power to subpoena. It's essential that there be an opportunity to examine evidence scientifically. These are things that are available in congressional hearings and in court rooms.

"Now it may be that somehow, someday, that's where something like this is going to have to be evaluated — where people have to give sworn testimony under penalty of perjury, and their evidence can be examined scientifically.

"We have sanctified science and have, therefore, not set up the kinds of procedures they set up in other businesses . . . . People are investigating themselves and each other without any rules of the game, without any power of subpoena, without any consequences for lying. That makes me nervous."

The first investigation into the Sobell matter was by an independent committee of enquiry commissioned by the Addiction Research Foundation (ARF) in Toronto where the Sobells have been employed since 1980 (**The Journal**, Dec, Oct, Aug, 1982).

In their Oct, 1982 report, the committee, chaired by Bernard Dickens, PhD, LLD, exonerated the husband-and-wife team stating "there is no reasonable cause to doubt the scientific or personal integrity" of the psychologists.

Recently, an investigation by a US congressional subcommittee also concluded there is no evidence to support allegations against the Sobells of scientific misconduct.

The Subcommittee on Investigations and Oversights of the Committee on Science and Technology, US House of Representatives, completed its "preliminary review" of the Sobells' Individualized Behavior Therapy (IBT) data in March.

Subcommittee investigator James Jensen told **The Journal** he had analyzed the Sobells' IBT data independently of the Dickens committee and had attempted, in several conversations with Dr Pendery, to obtain data to back up the Science article.

Dr Pendery recalls having had only one conversation with Mr Jensen.

Although empowered to subpoena evidence, Mr Jensen did not do so. He emphasized that his "routine" investigation included a review of critical documents supplied by the Sobells and proceeded on the "narrow focus of whether or not the Sobells could back up what they reported in the literature" concerning IBT.

Dr Linda Sobell told **The Journal**: "I think the examination went beyond our expectations. I think the importance of the congressional review is multiple. Mr Jensen has no basis for taking any position on any of the issues."

In a March 23 letter to Drs Sobell, Mr Jensen wrote: "Based upon my review of the evidence, I have concluded there is no evidence to support the allegations that your study was based upon fallacious, falsified, or otherwise-invented data.

"The correlation between your notes of contacts with patients, your phone logs, and the tape recordings of those contacts have convinced me that your report of the study was made in good faith. With the exception of errors in calculating the number of collateral contacts, your representation is an accurate one, and there is no evidence of willful manufacturing of data.


Mark Sobell


Linda Sobell

"My review of all available evidence supports the findings of the commission (sic) convened by the ARF . . . and fully supports their conclusions.

"Lastly," Mr Jensen stated, "the Division of Management Survey and Review (DMSR) at the National Institutes of Health (NIH), is in the process of conducting a review of this controversy (with the ADAMHA).

"Because the DHHS (department of health and human services) is the funding agency involved, I believe their review is a necessary one, in that they are ultimately the appropriate US government agency to be conducting any review or investigation of this matter."

Mr Jensen told **The Journal** the role of the subcommittee is to investigate any allegations of scientific misconduct where public funds are involved (**The Journal**, Oct) and to monitor the investigation to ensure its progress. (In this case, the funding body was the US National Institute on Alcohol Abuse and Alcoholism [NIAAA],

(See — Attack — page 3)

Greatest potential for drug abuse exists in Third World: DuPont

By Harvey McConnell

ATLANTA — Most Third World countries are like tinder waiting for the flame to touch off drug abuse wild fires, says Robert DuPont, MD.

"They are incredibly vulnerable, and have a very limited capacity to deal with the problems," believes Dr DuPont, president of the American Council for Drug Education (formerly the American Council on Marijuana and other Psychoactive Drugs), and former director of the United States National Institute on Drug Abuse.

"The greatest threat in the coming decade in terms of drug problems exists in Third World countries," Dr DuPont warned the annual conference here of the PRIDE (Parent Resources Institute for Drug Education).

He added: "They don't have a health system, let alone a drug treatment system. They have no


DuPont: incredibly vulnerable

way to control prescription drugs like benzodiazepines, sleeping pills, and stimulants, which are now sold in the market place.

"They don't have customs agents, law enforcement agents, or even border patrols, which could deal with the problems. They are vulnerable to drugs of dependence in a way which is truly staggering."

Dr DuPont said most drugs are not new, nor is the history or the biology of dependence. What is new is social values of pleasure, and lack of individual responsibility. The key to change is imparting the knowledge there are no safe drugs or harmless highs.

A paradox has existed in much of the world about drugs and drug problems.

Dr DuPont explained: "Most of the world never got diverted into this marijuana legalization/decriminalization kind of romance. Although there are other countries that have had that problem, particularly Canada and Western Europe, most of the rest of the world has had no doubt about the dangers of a drug like cannabis.

"On the other hand, most of the rest of the world has failed to grasp the gravity of the drug problem . . .

(See — Crop — page 2)

'Endemic' among California's poor

Sharp PCP rise tied to economy

By Harvey McConnell

SAN FRANCISCO — Experts believed PCP (phencyclidine) use had almost disappeared in California. Harsh economic times have shown they were wrong.


Smith: we thought it was gone

A sharp rise in PCP use, especially in the Hispanic population, is being reported in the San Francisco and Los Angeles areas.

"We didn't realize it, but PCP has remained endemic," David Smith, MD, medical director of the Haight-Ashbury Free Medical Clinic, San Francisco, has told **The Journal**.

Over the past few years, PCP use went way up, and then way down, "and we thought it was gone, but it was never really gone, it became endemic. Now we have an upswing, although I don't think it can be called an epidemic."

Economics is a big factor.

Dr Smith: "PCP is readily available, and if you want to get bombed out of your mind for a long period of time, and for relatively low cost, PCP is the drug to do it."

Although some prefer PCP alone, most users mix it with alcohol. In the Hispanic population this is considered 'macho,' and the result is a substantial increase in violence.

Dr Smith said their studies in the past have shown a lot of violence in PCP-alcohol users. He has been involved in several recent court cases where minor incidents evolved into random, gang-like murders.

Dr Smith: "A significant factor is that PCP is about the only thing they can afford. And although the older ones know the dangers, it is a very macho type of thing to use it and think you can handle it — the more risky, the more macho."

INSIDE

NEWS

Parents' response 'phenomenal' to offer of marijuana info

By Mark Kearney

OTTAWA — More than 300,000 parents of teenagers — about three times what officials expected — have requested information on the federal government's "Stay Real" drug education program.

"That's phenomenal," says Laurie Jones, communications officer with the health promotion directorate of Health and Welfare Canada.

"It's hard to estimate why (response is so high)," she says. "It seems parents are confused about marijuana and drugs and want more information. They are concerned about their kids."

The directorate has also answered 150,000 bulk-order requests for Stay Real booklets from schools, health associations, and other concerned groups, Ms Jones told **The Journal**.

In addition to the Stay Real program, an existing booklet, *A Parent's Guide to Drug Abuse*, has been revised under the new title *Straight Facts about Drugs and Drug Abuse*. This booklet takes a general look at drug-related issues and provides charts for quick reference with detailed information on seven categories of drugs.

The Stay Real booklet gives 24 pages of detailed information on marijuana and hashish for parents and for teenagers, with a special centre section designed to stimulate conversation between the two groups.

The booklet attempts to provide the basic facts, without a judgemental or moralistic message.

It is part of a three-year, $2.1 million drug education campaign launched by the government in March (**The Journal**, January).

The campaign, nearly two years in the making, has been conducted through television commercials and through the booklet, the availability of which was announced in a notice mailed with 3.67 million family allowance cheques in March.

The commercials, which positively reinforce avoiding drugs, ran for six weeks and are no longer on the air. Ms Jones says the advertisements have generated some response, but it's difficult to gauge their effectiveness.

The commercials will be broadcast again in the fall and next spring, she says. They will run for longer periods in British Columbia because cannabis use is higher there than in the rest of the country.

Print advertisements will also appear this fall in two, as-yet-unspecified, general interest magazines, Ms Jones says.

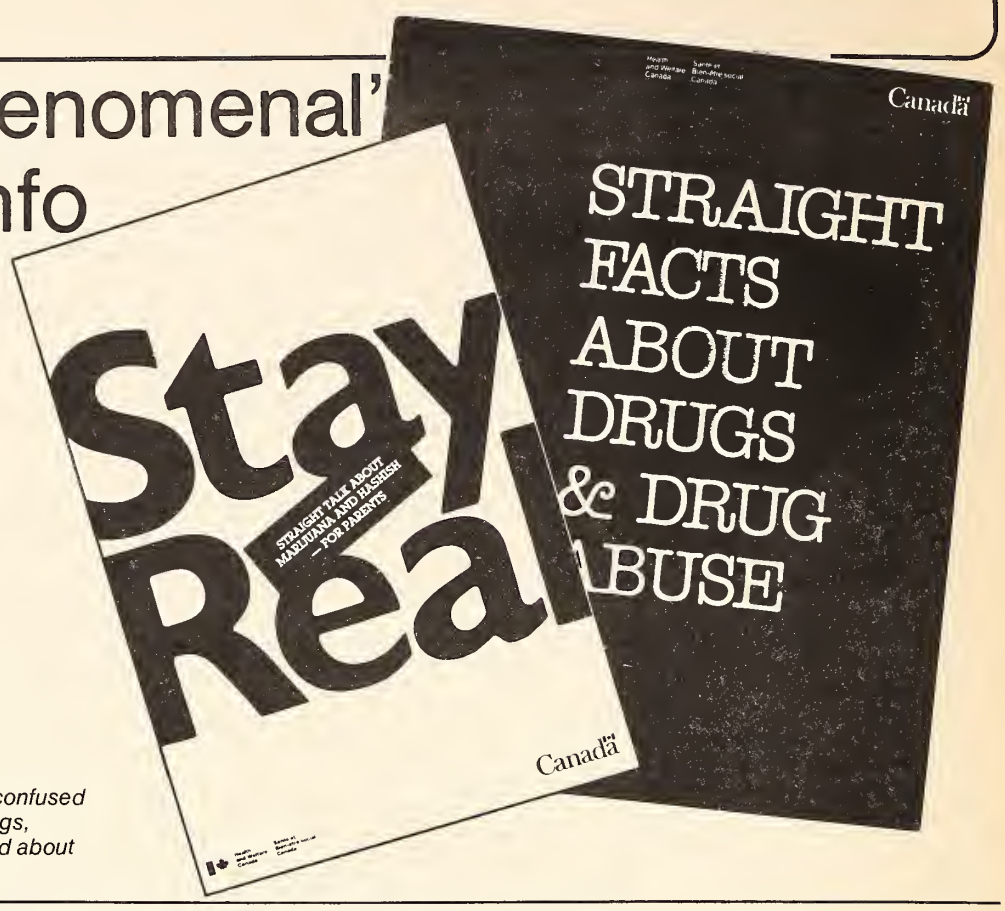
By next spring, the focus of the campaign will be directed more to students, she says, adding some teenagers have already responded.

The TV commercials will remain the same throughout the campaign, but the directorate will continue to evaluate their effectiveness.

Ms Jones says she doesn't expect the same phenomenal response to the fall campaign "but in terms of awareness I think it will help."

Stay Real won't affect the chronic drug user, but it should help delay or prevent onset of use by younger teenagers who are indecisive about trying marijuana or other drugs, Ms Jones told **The Journal**.

The directorate will also survey teenagers about their awareness of the campaign and their attitudes to drugs, she says.



Parents: confused about drugs, concerned about their kids

Briefly...

Educated quaffers

PARIS — Latin scholars may be a new target for beer advertisers here. A recent full page ad in *Le Monde* extolled the delights of certain Belgian beers and urged readers to look for clues in coming days to win prizes. The ad was printed entirely in Latin.

Oenology classes

KENT, OH — Classes in alcohol and alcoholism are being used to discipline Kent State University students charged with drunkenness on campus. The students are sentenced to classes in such things as how to serve wine, the history of alcohol control, the danger signs of alcoholism, and recipes for non-alcoholic drinks. For lesser offences, students may be sent to a class or two as a warning.

Logo means no go

TORONTO — A television advertising campaign urging people to find ways of getting home after drinking too much may not be allowed to run on stations all across Canada. The ad by Labatt Brewing Co Ltd, part of a $1 million campaign to battle drinking and driving, includes the Labatt corporate logo. The commercial has been televised in Ontario and Quebec, but regulations banning alcohol-related ads may block it in Saskatchewan, New Brunswick and Prince Edward Island.

Hitler's doctor says

NEW YORK — Adolf Hitler took 75 different medications during the four years before the end of World War II says a new book, *The Secret Diaries of Hitler's Doctor*, to be published this month by MacMillan Publishing Co. The book is based on the diaries and reports of Dr Theodore Morell, Hitler's personal physician from 1937 to 1945. Drugs included cocaine and adrenalin for conjunctivitis, belladonna and strychnine for gas, and 10 different painkillers and sedatives, including Eukodal, a synthetic morphine derivative.

Crop eradication should be a priority

(from page 1)

this is truly a global epidemic."

Most drugs come from plants which can easily be identified and relatively easily be destroyed. "We must raise the priorities for crop eradication of opium, marijuana, and the coca bush."

Crop eradication can work, as demonstrated in the past 15 years in Mexico and Turkey. But in the US, Dr DuPont said, "administrations . . . of both parties have failed to grasp the importance of crop eradication.

"And if anybody talks to you about crop substitution, you know that is the equivalent of their making a distinction between drug use and drug abuse. Crop substitution is a losing idea."

It is useless to go to other countries and give them seeds "to grow corn, or strawberries, or whatever else" in the belief this will stop cultivation of opium, or the coca bush, or marijuana. It never will, says Dr DuPont.

Dr DuPont: "Just as it has had to happen in a tough way about drug use, we have to say no to growing these crops — and mean it. And that means eradication of these crops at the source.

"This is not going to be done bilaterally, but it will be done multilaterally as other nations join together to do this. It offers great hope once we are serious about it."

Dr DuPont would like the US parents' movement to become international, because it "has changed the way the US views drugs, and it has empowered this nation to cope with a drug epidemic for the first time."

Dr DuPont said the parents movement may have played a major role in the current downswing in drug use in the US, but added, "let me make it clear that the drug abuse epidemic which began in 1965 in this country is continuing. I will estimate that a million new families in the United States will be adversely affected by drug problems this year that didn't have drug problems before."

He called on the parents' movement to tackle a problem it has so far avoided: teenage drinking. "The acceptance of teenage drinking opens the door to the process of intoxication, sets the stage, and establishes the normality, essentially, of chemical poisoning of the brain."

People, not government will solve alcohol abuse

HOUSTON — There is no way government alone can solve the problems of alcohol abuse; it must be done by the people with aid from the government on every level, says Margaret Heckler, United States secretary, department of health and human services (DHHS).

Heckler: light against darkness

Mrs Heckler said she "had not appreciated the enormity of the American dilemma on alcohol" until she recently became DHHS secretary, even though she supported a number of related programs during her 16 years in Congress.

She told the annual conference of the National Council on Alcoholism here that while many areas of US life and philosophy were open to debate, alcohol and its associated problems are stark: light against darkness, survival against death.

"We've got people on the moon, but we still haven't defeated drinking," she added.

Government cannot find the answers, but can use the tools of persuasion. "It is encouraging that our young people are starting to take the lead," she said.

Cocaine experimentation may be peaking: Smith

SAN FRANCISCO — While there continues to be a big rise in cocaine abuse, the number of people who start to experiment with the drug may be levelling off, says David Smith, MD, medical director of the Haight-Ashbury Free Medical Clinic here.

"It is possible we are beginning to reach the peak of cocaine abuse, although the number of those who have become addicted won't peak for another two or three years," Dr Smith told The Journal. However, his prediction may not be valid "as so many drug predictions have not proven to be valid."

A number of factors may be at work, including the vast amount of adverse publicity about cocaine effects, and drug education and awareness efforts.

Some cocaine addicts use bank money-machines like "a ritualistic human analogue" of the rhesus monkey self-administering the drug until it dies: at midnight at some banks in middle-class, San Francisco areas a few people can be seen pacing nervously until 12.01 am so they can withdraw another $100 to buy cocaine.

A number of cocaine recovery groups and Cocaine Anonymous groups have been started in the San Francisco and Los Angeles areas, Dr Smith said.

NEWS

Attack on Sobells shifting focus says Dickens

(from page 1)
under the aegis of the DHHS.)

Mr Jensen: "It was not our intention to make a judgement as to whether or not controlled drinking is a reasonable therapy. That's certainly an important question; I am not belittling it . . . . But my involvement was triggered by the allegations that research was falsified."

He added: "Believe me, neither the subcommittee nor the DHHS would have been interested had they known there were no allegations of fraud.

"Academic priority battles are a dime a dozen, and it's not an appropriate use of federal funds to be looking into this."

(In 1972, Dr Mark Sobell received a $4,911 grant from the NIAAA as principal investigator for the extended follow-up of the IBT-treated alcoholics. Later grants from the NIAAA, says Mrs Lehman of the ADAMHA, were not direetly for controlled drinking work.)

Of the Sobells' IBT work at Patton State Hospital in Patton, CA, in 1970 and 1971, Pendery *et al* wrote in Science: "Our follow-up revealed no evidence that gamma alcoholics had acquired the ability to engage in controlled drinking safely after being trained in the experimental program."

Drs Sobell had reported that 20 gamma alcoholics who received IBT with the goal of controlled drinking functioned significantly better than a control group receiving traditional, state hospital treatment, oriented toward abstinenee.

Pendery: procedural difficulties

Dr Pendery told **The Journal**: "My concern, my overriding concern, is the question of the validity of the Sobells' findings, because they are so widely cited and taught. I'm not interested in the question of, 'was it fraud, or something else?'

"The question is, who is going to look at the (validity) because the Dickens committee wouldn't. And until now, it's not my understanding that the ADAMHA is interested in that either."

The ADAMHA's Mrs Lehman told **The Journal** that "an important distinction that we would like to make is that we really are not looking at the validity of the science, but strictly as to whether there has been any misconduct in science. The key to the depth and scope of the review group's work will be the amount of information that Dr Pendery provides for us."

Dr Pendery told **The Journal** she is meeting with her lawyers about the ADAMHA review because there are "some real procedural difficulties" involved. She is concerned that the Freedom of Information Act will allow some of her confidential data to become a matter of public record, and, perhaps more importantly, that the ADAMHA review "is not interested in the validity" of the Sobells' findings.

Michele Applegate, associate administrator for extramural programs, the ADAMHA, told **The Journal** the current review is still in the early stages. The committee, known as the steering group, had met twice as of press time with no specified target date to complete its review.

Ms Applegate, who has "lead responsibility for misconduct in science policy" at the ADAMHA, is serving as executive secretary to the steering group. She said it will bring in external consultants as needed.

She added the steering group has been advised of the congressional subcommittee's investigation and conclusions and "has taken this information into consideration in deciding how to pursue its investigation."

Ms Applegate said under other circumstances, the NIAAA, as the original funding body for the Sobells' IBT research, might have conducted the review. However, because Dr Pendery has expressed some concern about how the NIAAA had handled the Sobell issue earlier, the review has been "elevated out of the institute." Thus, the ADAMHA, which administers the NIAAA, asked that the NIH "provide investigative staff capability for us," she said.

Mrs Lehman added: "It isn't as though we had any concerns about the institute, but the eoneerns were expressed from the outside by Dr Pendery."

Mrs Lehman said that once the steering group concludes its review of the Sobells' data it will also examine Dr Pendery's allegations against the NIAAA. "We're concerned about that too, and we'll be looking into the matter."

The Sobells said they have been contacted by William Butler, an investigator for the DMSR, who is assisting the steering group. They have indicated to Mr Butler their willingness to cooperate with "whatever the group is intending to do," said Dr Linda Sobell.

Meanwhile, Professor Dickens of the faculty of law at the University of Toronto says the steering group has a copy of his committee's report. "There's nothing I can add because the knowledge and conclusions are in the report."

The mandate of the Dickens committee of enquiry was to review the original research by the Sobells, and their follow-up studies; to consider the Pendery et al criticism, and other relevant material; to allow the Sobells an opportunity for a rebuttal; and to judge whether there had been misrepresentation of data.

Dr Pendery told the Houston meeting that the report of the Dickens committee was "a whitewash" and "a sham."

Later, she told **The Journal** she believed the members of the committee were not impartial and said she disagreed with their findings. She also said the "general impression that was created was that the Sobells' research was valid."

Prof Dickens told **The Journal** the controversy around the Sobells' work appears to be shifting focus.

"The original attack on the Sobells was that their results were fraudulently achieved.

"I think Dr Pendery is no longer arguing the fraud and the falsifications. She is now dealing with more methodological, more scientific issues."

Mark Sobell: a right way

Linda Sobell: cooperating

Prof Dickens continued: "I think she's shifting the ground of her attack in that the Science article expressly said it was not dealing with the Sobells' methodology.

"Our committee was concerned with allegations, particularly by Dr Maltzman, (Professor Irving Maltzman, former chairman of the psychology department, at the University of California, Los Angeles), that the Sobells had engaged in fraud. And we addressed the question of fraud.

Dickens

"It seems now that Dr Pendery is not persisting in allegations of fraud but is claiming to deal with seientifie matters. The Seienee artiele did not."

At the Houston meeting, Dr Pendery also criticized a recent article in the magazine *Psychology Today* about the controlled-drinking debate, was herself criticized for comments she made about the "lush lifestyles" of scientists, and praised a recent US television program about her challenge to the Sobells' work.

Dr Pendery said the article by Stanton Peele, PhD, Through A Glass Darkly (April), was a "pro-Sobell article" that presented their eontrolled-drinking outcomes as "straight data."

Dr Peele wrote: "The assault on controlled drinking . . . has prevailed in forming the climate of opinion about alcoholism in the US. According to Peter Nathan, a professor of clinical psychology at Rutgers University, no alcoholism center in the US is using controlled drinking as official policy."

Peele

Dr Peele continued: "In contrast, Heather and Robertson, the Scottish researchers, report that in the United Kingdom 'most treatment centres now accept the principle of controlled drinking.

"This difference between the two countries in public policy," wrote Dr Peele, "is not the result of scientific inquiry. Rather, it reflects political forces and prejudice in America that forbids a reasonable discussion of the issues. The essential question is whether, in this atmosphere, we can find the best way to combat alcoholism."

Delegates to the Houston meeting chided Dr Pendery for her remarks about some scientists.

She had said: "Science today is not Madame Curie working self-sacrificially in the basement.

"Seience today is big business. Science today includes one of the lushest lifestyles you can have. We have credit cards, secretaries . . . . These kinds of inducements attract perhaps a different type of person into the field than you would probably have had when it involved self-sacrifice."

But Dr Pendery praised the 60 Minutes program on CBS-TV, which traced some of the original 20 subjects in the IBT program and reported on continuing individual involvement with alcohol. She told **The Journal**, "It did a terribly thorough investigation which is the reason I cooperated with them.

"I was aware you have to cooperate with some people because you lose credibility if you don't."

About the controversy in general, Dr Mark Sobell told **The Journal**: "There is a right way of conducting seientifie critieism, espeeially when it may involve wrongdoing, and surely everybody involved in that process is concerned with exposing any malfeasance because you want to root that out of the profession."

He explained that in the US the psychology profession is policed by the American Psychological Association (APA). If a complaint is lodged with the APA Ethics Committee, for example, there is a set of specified procedures for investigating the eomplaint and taking action, if warranted.

"So it's not as though procedures don't exist," said Dr Sobell. "The problem in this case, and the kind of precedent it raises, is that the process was violated. It wasn't followed, and all the media events and such were the results of not following that process. So it's really not so much establishing procedures, it's how do you get people to use them?

"In this case people were able not to use them and to follow that course of action quite successfully. That's the problem. Nobody asked, 'who has looked into this?' Nobody said, 'are you sure?' Nobody said, 'what does the other side say?'"

Meanwhile, William Mayer, MD, administrator of the ADAMHA, and acting director of the NIAAA, told the Houston meeting that he had withheld circulation of a curriculum guide prepared by the Sobells and intended for psychology students.

Mayer

He later told **The Journal**: "I don't see myself in any sense as a censor. But, on the other hand, I am responsible for what is printed under the label of the NIAAA."

On Dr Mayer's behalf, Mrs Lehman told **The Journal** the manual would not be circulated because "on a further review of the draft-manuscript submitted by the Sobells, we have decided not to go forth with its publication at this time."

The manual exists in a pre-publication format, complete with cover, in Dr Linda Sobell's office at the ARF. It was submitted at the NIAAA's request by the Sobells in the summer of 1981, said Mark Sobell. He added: "It was a broad, general document with some basic information."

Dr Pendery referred to the document in her Houston presentation: "This is a long document by the Sobells and includes the topic of controlled drinking — only the favorable literature, of course — and recommends it as a good area for trainees."

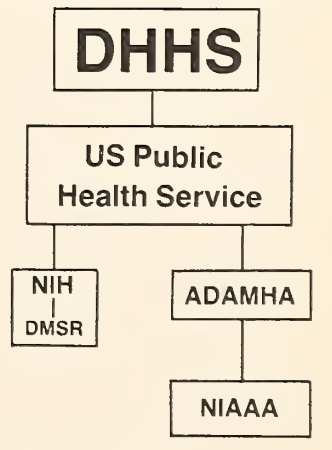
Linda Sobell: "The reason it's in a 'pre-pub' format is because it satisfied all of the reviews, and it was sitting, according to our information, at the government printing house just waiting for the budget to be approved, because the dollars were tied up at the printing house, and so forth."

The Sobells don't know why the manual has been withheld.

Wayne Howell's column is on page 9

Primary groups involved

MEMBERS OF THE ADAMHA steering group are Robert Traehtenberg (ehairman), deputy administrator, ADAMHA; Harold Margulies, MD, director, Health Teehnology Assessments, National Center for Health Serviees Researeh, Publie Health Serviees; Jerome Levine, MD, chief, Pharmacology and Somatie Treatments Researeh Braneh, National Institute of Mental Health; Markku Linnoila, MD, PhD, clinical director, division of Intramural, Clinical and Biologieal Researeh, NIAAA; and William Raub, PhD, assoeiate direetor for Extramural Researeh and Training, NIH.



Dietionary of Aeronyms

ADAMHA —	Aleohol, Drug Abuse and Mental Health Administration
APA —	Ameriean Psyehologieal Assoeiation
ARF —	Addietion Researeh Foundation of Ontario
DHHS —	Department of Health and Human Services
DMSR —	Division of Management Survey and Review of the National Institutes of Health
IBT —	Individualized Behavior Therapy
NIH —	National Institutes of Health
NIAAA —	National Institute on Alcohol Abuse and Alcoholism

NEWS

RESEARCH UPDATE

Prenatal abstinence therapy

Therapy for pregnant women who are heavy drinkers can be successfully incorporated into a routine prenatal care program. A study at the Boston City Hospital's women's clinic conducted between 1974 and 1979 found that of 49 pregnant women who participated in at least three counselling sessions, 67% reduced alcohol consumption before the third trimester. Counselling focused on reduction of alcohol use and other issues important to the women and the positive outcome of the pregnancy. Henry Rosett, MD, Lyn Weiner, and Kenneth Edelin, MD, found the desire to have a healthy baby was a powerful motivating force in the therapy, which aimed at total abstinence. The researchers found young, nulliparous women were more likely to reduce consumption, while women who said they drank when they were nervous or depressed had a less favorable prognosis. They concluded: "Women who drink heavily, whose offspring are at greatest risk, will respond to individual supportive counselling provided by their health care professionals."

Journal of the American Medical Association, April 15, 1983, v.249:2029-2033

Iron absorption inhibited

Coffee and tea can significantly reduce the amount of iron a person absorbs from a meal, a study at the University of Kansas Medical Center has shown. When 37 volunteers were given coffee or tea following a hamburger meal, nonheme iron (iron contained in a protein) absorption was found to be inhibited by 39% and 64% respectively. Further studies by Timothy Morck, PhD, Sean Lynch, MD, and James Cook, MD, from the Kansas University hematology division, found the inhibitory effect of coffee is dose-related, and the effect is similar whether the coffee is consumed with the meal or one hour later. Because of the popularity of coffee, the researchers said "these findings may have important implications for iron nutrition," and the effect may be relevant in choosing the vehicle and iron salts for fortification programs.

American Journal of Clinical Nutrition, March 1983, v.37:416-420

FAS message working in Seattle

Women in Seattle, WA, a city with a high degree of community awareness of alcohol's effects on the fetus, appear to be absorbing the message that drinking can effect their child's health. A study of changes in the drinking and smoking habits of pregnant women in the city, were examined between 1974 (when the first announcement in the United States of the fetal alcohol syndrome was made) and 1981. A study team from the University of Washington found the number of women who reported any alcohol use around the time of the first prenatal visit dropped to 42% from 81% while the number of smokers dropped to 22% from 25% over the six-year period. However, in the study group of primarily white, middle-class women, there was no decrease in the proportion of women who reported heavier drinking.

American Journal of Obstetrics and Gynecology, March 15, 1983, v.145:716-724

Tremor and propranolol response

Alcohol cannot be used to judge how well a patient with tremor will respond to propranolol, a study suggests. Two researchers studied the action of intravenous alcohol on patients with a variety of tremors and compared the response to propranolol in patients with essential tremor. William Koller and Nabil Biary found alcohol did not effect resting tremor in 10 parkinsonian patients and was also ineffective in five patients with intentional cerebellar tremor but did reduce tremor in all of 15 patients with essential tremor. However, they also found that four of these patients had no response to propranolol, disproving the suggestion that alcohol could be used as a simple test to predict the response to this drug.

Neurology, April 1983, v.33,suppl 2:125

Paregoric for addicted newborns

An opiate has been found to be better than a central nervous system (CNS) depressant in treating the neonatal abstinence syndrome. The first known comparative prospective study of the two therapeutic approaches was conducted by researchers from the division of neonatology, Beth Israel Medical Center, and the department of biostatistics, Mt Sinai School of Medicine, New York. Paregoric (camphorated opium tincture BP) was compared with the CNS depressant phenobarbital in the treatment of 102 neonates with symptoms of neonatal abstinence born to drug-dependent mothers. While both drugs initially appeared to control neonatal abstinence signs equally well, seven of the 62 phenobarbital-tested newborns had abstinence-associated seizures within the first month of life; the 49 infants treated with paregoric had no such seizures. The researchers concluded paregoric "is the treatment of choice where therapy is considered necessary."

American Journal of the Disturbed Child, April 1983, v.137:378-382

Infarction risk unchanged

Smoking cigarettes with nicotine levels as low as 0.8 mg and carbon monoxide levels less than 10 mg does not protect men from the dangers of myocardial infarction associated with smoking regular cigarettes, a Boston study suggests. In 502 cases and 835 controls, the study evaluated the relationship of nicotine and carbon monoxide levels to the risk of non-fatal first myocardial infarction in men between ages 30 and 54. Researchers from the drug epidemiology unit, Boston University School of Medicine, and the department of epidemioogy, Harvard School of Public Health, found an approximate tripling of the rate of myocardial infarction among current smokers. It "did not appear to vary according to the amount of either substance."

New England Journal of Medicine, Feb 24, 1983, vol. 308:409-413

Pat Rich

Silent conspiracy surrounds problems of addicted MDs

By Mark Kearney

NEW YORK — Many physicians abuse alcohol and other drugs because of the "M Deity syndrome," says a Georgia physician.

Martha Morrison, of Emery University and the Ridgeview Institute, Smyrna, GA, says many physicians find it difficult to handle the pressures of the medical world and to meet their own high expectations.

About one in eight will end up with a "significant drug or alcohol problem," she says. Doctors also tend to deny the problem because of the stigma their colleagues and society attach to it, she told the American Psychiatric Association meeting here.

A conspiracy of silence exists in the medical world among other doctors who are aware of the problems, Dr Morrison says. They reinforce the "M Deity syndrome" and often accept the denial by the impaired physician.

"This is what makes it difficult for physicians to ask for help — (something) they rarely do."

Dr Morrison, a fellow in addictionology, says in many cases, the solution is to coerce physicians into treatment.

Since 1975, the Medical Association of Georgia has helped more than 500 doctors through its Impaired Physicians Program. Dr Morrison says in many cases a doctor will be confronted by colleagues who have proof of the impairment.

Usually two or three physicians who are recovering from a drug problem themselves take part in the confrontation and explain how the program works.

The Georgia treatment program lasts four months and is followed by 20 months of aftercare. During treatment, the physicians are detoxified, engage in group therapy, are counselled, and participate in other programs such as Alcoholics Anonymous.

Those who complete the program have about a 90% success rate, she says, compared to the United States national average of 50%. The Georgia program has served as a model for others in the US and abroad.

Despite this success, however, impaired physicians present special difficulties not typically encountered in other patients, says Alan Stoudemire, MD, an assistant professor of psychiatry at Duke University in North Carolina.

Physicians who are used to caring for patients may find the sudden role reversal "a critical dilemma," Dr Stoudemire says.

Morrison: one in eight

Physicians treating a fellow doctor may not know how best to handle the situation or may feel awkward if their patient is a senior colleague. Dr Stoudemire recommends using other doctors as consultants when treating an impaired physician.

There is also the problem of weighing the patient's right to confidentiality against the need to report severe impairment of a physician to state medical authorities, Dr Stoudemire adds.

Enforcement alone won't stop drugs

ATLANTA — Wall-to-wall law enforcement will not solve the problem of drug use and abuse in the United States. It must involve education, prevention, and the community, says Carlton Turner, PhD.

While war must be waged against drug traffickers, and efforts must continue up and down the coasts and borders, "there is no way law enforcement alone will solve the drug problem," said Dr Turner, director of the White House Drug Abuse Policy Office.

"You can put wall-to-wall policemen around our 96,000 miles of borders, you can put wall-to-wall sheriff's deputies around every county, and you won't solve the drug problem."

Dr Turner told the conference here of the PRIDE organization, (Parent Resources Institute for Drug Education): "Anyone who thinks law enforcement can do it without the support of the community has rocks in their head."

Dr Turner said he believes the proper role for the federal government is to give support to education and prevention programs; to encourage communities, private industry, and business to get involved; and to get the medical community to accept substance abuse as a medical problem.

Knowledge gained from research must be conveyed to the public, "but it is ludicrous to have a research program that is not tied to what is happening in the street."

The only way to stop the problems of alcohol and drug abuse "is to energize every element of our society," he said.

Stop-smoking kits help say Canadian doctors

By Incor Jowat

TORONTO — A kit to help doctors encourage patients to quit smoking has been well received by Canadian physicians, but its effectiveness is still uncertain.

Kristian Kirkwood, EdD, director of research for the College of Family Physicians of Canada, recently reviewed the results of an evaluation of the Quit Smoking Kit (QSK), adapted for Canadian use by the Canadian Cancer Society from the original American National Cancer Institute kit.

At the annual meeting of the College, Dr Kirkwood described the survey involving 188 family doctors from across Canada who were sent copies of the kit and material to distribute to 50 patients each. The survey concentrated on the perceived value of the QSK rather than its efficacy.

The kit contains material for both doctors and patients. Waiting room posters and desk cards are provided for doctors as well as 'smoker' stickers, which the doctor may place on the patient's chart, to add impact.

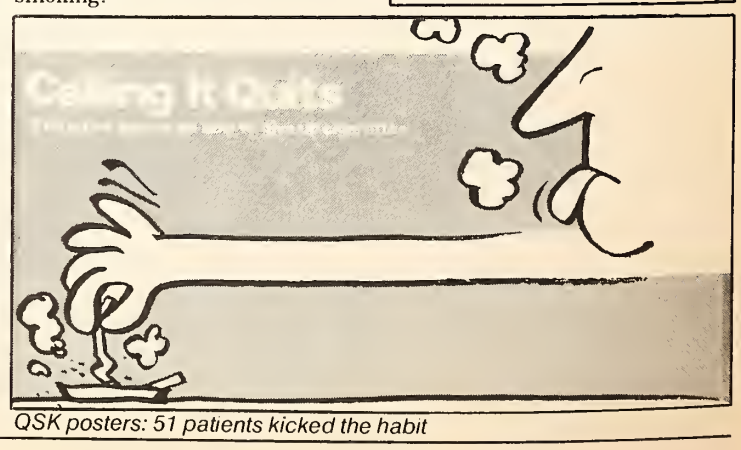
When patients who want to quit smoking are identified, the doctor gives them a self-test to find out why they smoke. They are also given a booklet on how to quit. One week later the doctor mails them a brochure outlining the immediate and long-term benefits of quitting smoking.

The QSK also contains a patient progress card to be mailed later, for patients to describe how successful their efforts have been.

Dr Kirkwood said more than 60% of the doctors said the material discussed in the office appeared to be well received by the patient. The waiting room poster and desk cards did not seem to have as great an impact.

He stated 84% of the doctors said they planned to continue using the QSK, and 77% said they would recommend the kit to other doctors.

Dr Kirkwood said 23 doctors had had 51 patients respond that they had kicked the habit completely, 42 doctors said 145 patients were still struggling but were confident they could quit smoking for good, and 34 doctors said 155 patients admitted they were having trouble quitting.



QSK posters: 51 patients kicked the habit

'Something other than money'

Ontario medics take a stand, public applauds

TORONTO — A campaign by the Ontario Medical Association (OMA) to publicize the association's views on a variety of topics through television and newspaper advertisements has been well received by doctors and the public alike.

Hugh Scully, MD, chairman of the committee, said initial reactions to the campaign have been favorable.

He said doctors are pleased the OMA is initiating action rather than reacting to events and believe the issues are ones doctors should express concern about.

The seven-week campaign, which concluded in April, featured a 60-second television spot in which the Ontario health care system was discussed and ads in daily newspapers discussing second-hand smoke, drunk driving, and the disposal of toxic waste.

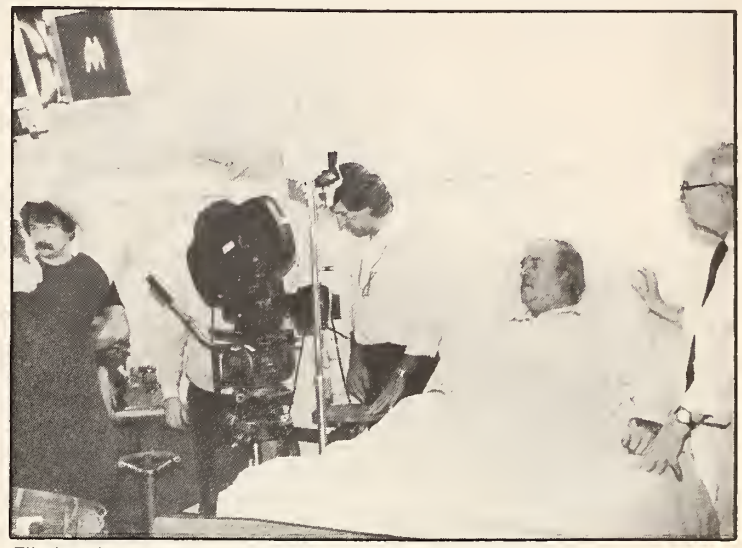
The topics were chosen by the OMA communications committee as areas of special concern for doctors.

Dr Scully said the public has expressed approval especially for the newspaper advertisements dealing with the hazards of second-hand smoke and the disposal of PCBs (polychlorinated biphenyls).

Reaction to the television commercial has been more mixed. The CBC television network would not run the ad because of a policy against controversial material in commercials (although this ban did not apply to CBC affiliates), and the British High Commission was upset by the manner in which the British medical system was portrayed. The ad implied British doctors "are totally controlled" and that most are "paid a salary so they are assured of an income whether they see their patients or not."

However, Dr Scully said the public received the main message of the commercial — that the OMA is concerned the delicate balance in the Ontario health care system may be lost. And some people had been prompted to say: "It's nice to see you comment on something other than money." That, Dr Scully said, was one of the reasons the campaign was launched.

Depending on results of an assessment, the OMA may consider a similar campaign for the fall.



Filming the message: the delicate balance may be lost

GILBERT

'Even researchers might benefit from knowing the business better . . .'

Beverage futures

By Richard Gilbert

I spent a day in April at the Prince Hotel in North York, Canada's fourth largest city, listening to speakers at the Third Annual Canadian Beverage Marketing Seminar. The theme of the seminar was Change and the Opportunities of Change.

The participants were almost all marketing executives from companies engaged in at least one aspect of the soft-drink, alcoholic-beverage, or tea and coffee business. The other side, so to speak, consisted of a representative of the Alberta Alcoholism and Drug Abuse Commission (AADAC), in attendance with the communication consultants who develop AADAC's prevention campaigns.

The AADAC was smart to pay for these people to participate. How better to get ideas about prevention than to listen to experts on making consumption go up? It is as if a coach were given a seat at the other team's strategy session.

So, what's going on in beverage marketing? The first thing that hits you is the preoccupation with the future. Marketing executives are fascinated by what their world might be like next year, the year after, and even for decades to come. The past and the present are of little interest except as they provide clues that help these executives position themselves for maximum sales.

Beverage researchers by contrast, at the Addiction Research Foundation and elsewhere, are preoccupied with the past, for the very good reason that only the past produces data. The future is intangible and unfathomable. Speculation is not an academically-respectable exercise.

Caught in between are the prevention specialists and the policy advisers. Their mandate is to affect the future, but their resources are usually researchers rooted in the past.

What did the participants learn about the future? And what should preventionists and policymakers be paying attention to?

Big generation

The seminar's first contributor was John Kettle, described in the Speaker Profiles as "a futurist . . . since 1966, Kettle has written over a million words on the future . . . he has been consulted by local, provincial, federal, and international (the UN) governments." (A million words, by the way, is a lot of words — the equivalent of 500 of these columns laid end-to-end.)

Kettle dwelt on demographic and economic change, painting a broad landscape of the next 25 years. He traced the "big generation," the seven million Canadians born between 1951 and 1966, which is now making its way up the pyramidal representation of the age distribution like a whole sheep passing through the body of a boa constrictor. The bulge is smoothed out as it moves through, but it is still evident right to the end.

Kettle noted five firsts for the big generation: (i) It had high school education as the norm. (ii) It was brought up in an economic boom. (iii) It spent more time watching television than with either parent, at school, or on the street, and thus watched 350,000 commercials and soaked up the values of New York, Los Angeles, and London, England as much as those of London, Ontario. (iv) It grew up knowing about drugs. (v) City living was the norm.

Each of these effects — education, financial security, cultural independence of parents and community, drugs, and urban life — was said by Kettle to be individuating, meaning that relatively little of the behavior of this generation, now 25 years old on average, depends on cultural norms and past practices. As a result, choices of lifestyle and, incidentally, beverage preference, are much less predictable than before. Life is tougher for the marketing specialists and also for the preventionists who have to counter the effects of clever marketing.

Fluidity

Employment trends dominated Kettle's presentation on the economy. He highlighted women in the labor force and unemployment. In 1953, only 24% of women worked. Now 52% work. In 1953, 95% of the labor force worked full-time, 2% worked part-time, and 3% were unemployed. Last year, at any given time, only 73% of the labor force worked full-time, 14% worked part-time, and 13% were unemployed.

The composition of the work force has become very fluid. In 1953 it consisted almost entirely of men aged 15 to 64 years and women aged 15 to 24 years, all working full-time. Now, women up to retirement age are working, or looking for work. (By 2001, said Kettle, there will be as many women working as men.) Men and women are moving into and out of the work force and between categories of employment. Two groups are being left out as these changes occur: young adults, some 20% of whom are unemployed across Canada, and middle-aged men laid off from manufacturing plants, for whom retraining is difficult even when available.

Kettle said little about the impact of these and other profound economic changes on beverage use. My own guess is that two factors will be critical: disposable income and the amount of time spent at home. Without increases in productivity, the effect of fluidity in the work force will be to spread a given amount of total income around more, meaning overall a decline in disposable income because more people will make ends meet, but fewer will have a surplus. A lower average disposable income means less spent on alcoholic beverages and more on soft drinks, tea, and coffee, which are less expensive. If more people are out of the home at work, or looking for work, a higher proportion of beverage consumption may be done away from home, meaning that the price will be higher and less will be consumed, particularly less in the way of alcoholic beverages.

Looking ahead, then, we can see general trends toward a decline in the use of alcohol and an increase in the use of other kinds of beverage. But, perhaps productivity will increase, and disposable income will rise with its inevitable effect of increasing alcohol use. Also, enormous numbers of people may work at home, tied to computer terminals, but free to drink inexpensive alcohol while they work. Beverage marketers will be watching all of these trends closely, and they deserve equal scrutiny by preventionists and policy advisers.

Grocery stores

The rest of the seminar comprised tips on dealing with the shifting sands of the beverage marketplace. Dan Aronchick of the Brand Development Group spoke about consumer dissatisfaction with beverages. People seem mostly happy about wine, said Aronchik, but worried about liquor because of health reasons, about beer because of its smell and macho image, and about tea and coffee because they can't make them properly.

Douglas Tigert, dean of management studies at the University of Toronto, and Don Lussier, assistant general manager of the Manitoba Liquor Control Commission, debated among other things what Tigert described as the inevitable move to allow sale of beer and wine in grocery stores "because the government of Ontario is so strapped for revenue."

Lussier countered by noting the enormous efficiency of present methods of distribution. He said that prices could rise by some 30% if grocery outlets sold alcoholic beverages. There would be a consequent loss of revenue to government because of falling consumption.

The star performance was the first session in the afternoon. George Tidball, founder and president of The Keg restaurants, told how the trend to eat out and drink with the meal is being replaced by drinking out and eating with the drinks. The secret of getting people to drink out, said Tidball, is to charge less. The Keg restaurant chain is Grand Marnier's largest account in the world and sells the liqueur for less than it is sold by the bottle in liquor stores. The Keg's home province, British Columbia, makes bulk purchasing of wine by restaurants difficult. However, Tidball intimated that this might be changed with a contribution to the political party of his choice.

"I am an aggressive right-winger," noted Tidball. Not a lot of beer and soft drinks are sold at The Keg, he continued, "they are not the name of our game."

Lobbying

The result is that the average adult Keg customer knocks back four drinks, two before the meal and two during and after. Someone noted that perhaps half of his customers leave with more alcohol in their blood than is safe for driving. Tidball responded that he is lobbying to raise the legal limit.

Finally, Douglas Newell, a media analyst, spoke about the enormous fractionation of the media that has occurred during the past 20 years and is continuing apace. Just about everything has doubled. There are twice as many radio and television stations as in the early 1960s, and twice as many magazine titles are published. But the amount of time spent attending to media has hardly changed. Only movie-house attendance has declined, by nearly half. Advertising will have to be more and more precisely targeted to particular audiences. (So, I might add, will prevention campaigns.) Newell quoted Ogden Nash: "Progress may have been all right at one time but this time they have gone too far."

The uncertainties posed by the firsts of the big generation and the media changes (including pay TV, video recording, and computer bulletin boards) will make for a hazardous life for practitioners on both sides of the sales counter. As marketing strategies and their effects become more subtle, agencies concerned about the impact of beverage use on society will have to develop a richer understanding of the beverage marketing business in order to fathom what is going on.

Even researchers might benefit from knowing the business better; the marketers have some interesting comments on why people drink as much or as little as they do. A good place to start would be to attend the Fourth Canadian Beverage Marketing Seminar in the spring of 1984 — if they let you in.

NEWS

Beverage industry thwarts controls, broad-based counterattack needed

By Harvey McConnell

HOUSTON — The alcohol beverage industry in the United States has been powerful enough so far to thwart warning and ingredient labels on containers, curbs on advertising, and increases in federal alcohol taxes.

This is the view of Ernest Noble, MD, PhD, Pike Professor of Alcohol Studies, and director, Alcohol Research Center, University of California at Los Angeles.

Dr Noble moderated a panel discussion on the need for such measures at the annual meeting of the US National Council on Alcoholism here.

Alcoholics are no longer considered moral lepers; there is now effective treatment, and the problems alcoholism creates have been brought to the public forefront, said Dr Noble, a board member of the NCA and former director of the US National Institute on Alcohol Abuse and Alcoholism (NIAAA).

"However, despite all these efforts, we are losing the battle against alcohol problems and alcoholism," he said. And more effective prevention techniques must be developed.

"We have been taking people out of the water and trying to resuscitate them but have not been asking who is upstream pushing them in.

Noble

DeLuca

It is about time to ask those questions if we are to do our job right."

John R. DeLuca, who succeeded Dr Noble at the NIAAA and is now a vice president and director of the medical department at Equitable Life Assurance, New York, NY, recounted the fierce opposition four years ago to the idea of warning and ingredient labels.

One liquor lobbyist said the industry "will go to the wall" to prevent any label on containers which would link alcohol and birth defects.

Mr DeLuca said those pushing for new prevention methods must bear in mind that "while we are dealing with a product which is a drug," it is a drug the majority of people enjoy. Alcohol is used in most social settings and has a place in the minds of US citizens.

One argument offered against warning labels was that this was not the best way to convey information to consumers, he said. While promises were made that this communication would take place, Mr DeLuca said it had not happened.

The US public is being deliberately deprived of "some basic scientific information which the government knows and will not release," he said.

A broad-based constituency is necessary to make an impact on the politicians in Washington. The current campaigns against drunk driving provide a "window of opportunity" to push for change, for the government "to give us the scientific information they know," Mr DeLuca said.

Michael Jacobson, PhD, director of the Center for Science in the Public Interest, Washington, DC, attacked the advertising and marketing methods of "the most tenacious drug pushers around."

The industry spends $1 billion a year "to persuade more people to drink and current drinkers to drink more," he said. Two companies spend at least $150 million a year — more than is spent on alcohol education and prevention programs combined.

Dr Jacobson said the main targets are youth and heavy drinkers. Vast sums are spent on college campuses, from ads in college newspapers to free beer, T shirts, and the use of students as salesmen.

The industry is turning to the untapped Black and Hispanic market, and major efforts are being made to influence women, Dr Jacobson observed. "The 10th anniversary issue of *MS* magazine had 31 advertisements for alcoholic beverages."

The centre obtained a copy of a beer company memo which said one brand, which is aimed at the 18- to 24-year-old market, has 10% more alcohol than their regular beer.

There is no interest in Congress at the moment in reforming alcohol advertising and marketing, said Dr Jacobson.

Although clampdowns would not have any effect on current drinkers, they might help reduce the number of problem drinkers in the future.

He said control measures should include a ban on marketing aimed at youth and heavy drinkers; a ban on television and radio beer and wine ads; and a balancing of ads with a warning notice.

"But nothing will happen until people concerned bring pressure to bear on government and industry."

Dan Beauchamp, PhD, assistant professor at the school of Public Health, University of North Carolina, said in many states beer is as cheap as, if not cheaper than soft drinks. In many supermarkets, beer and soft drink six-packs are stacked close together.

Tax increases need not be horrendous to make a difference in consumption, he said.

It's no holiday

Poster warns smugglers

TORONTO — Alarmed by the recent increase in the number of Canadians arrested abroad for illegal drug activities, the department of external affairs has launched an education campaign warning that spending time in a foreign jail is no holiday.

The program includes a poster, radio and television public service announcements, and interviews. It's aimed at deterring Canadians from getting involved in illegal drug activities — before they leave the country, says Robert Lapointe, a consular policy officer involved in organizing the program.

Mr Lapointe said last year close to 800 Canadians spent some time in foreign jails — 300 of them on drug-related charges.

"Back in the early '70s there was an epidemic of people arrested abroad for trafficking," he said. At that time, most offenders were between the ages of 17 and 25 years. Following a decline, the numbers of those involved in drug dealings abroad has increased, and there is no typical offender profile.

"People from virtually all age groups are involved," says Mr Lapointe.

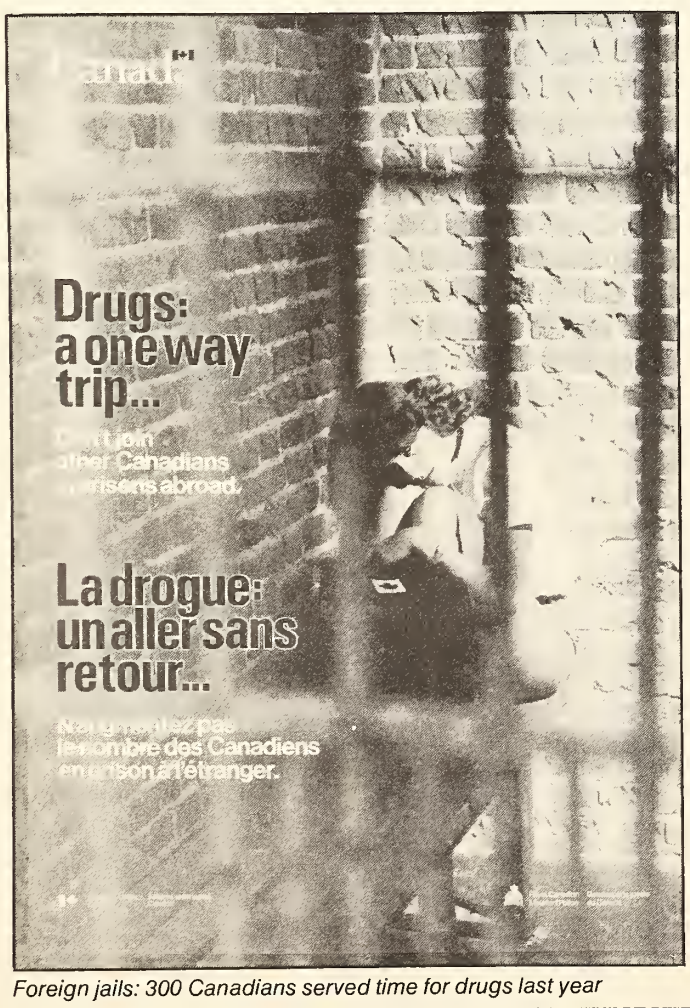
"What appears to be the bulk of the problem is people being recruited in Canada to act as mules," he said. They are offered a free trip and cash on return, merely for picking up a package in another country. He said that while some people are deliberately getting involved, others are "just susceptible to being recruited."

It is to this group that the department has geared its information campaign.

The 50,000 posters, produced and distributed with assistance from the RCMP (Royal Canadian Mounted Police), will be displayed in high schools and colleges, airport departure lounges, airline ticket offices, and public buildings throughout the country. Larger billboards will be placed at Toronto, Vancouver, and Mirabel (Montreal) airports.

Mr Lapointe said "it is not a moralizing campaign, we are just saying what we are seeing abroad.

"We want to get to people before they leave Canada and tell them what the problems are and what the consequences are."



Foreign jails: 300 Canadians served time for drugs last year

Care not cure sought by some in detox

By Mark Kearney

NEW YORK — Treatment may be counterproductive for some alcoholics who enter detoxification programs seeking "care, not cure," says a Nova Scotia psychiatry professor.

Alex Richman, of the department of psychiatry and preventative medicine at Dalhousie University in Halifax, NS, says some alcoholics reject treatment because they refuse to accept the role of "patient" in therapeutic programs.

They repeatedly enter detoxification seeking the privileges of the health care system (shelter and asylum) without complying with attempts to improve their health, he says.

"It is precisely this failure to accept the obligations of the sick role that makes rehabilitation so difficult," Dr Richman said at the American Psychiatric Association annual meeting here.

These so-called "detox-loopers" are admitted repeatedly to programs without demonstrating longer-term rehabilitation gains, he says. Data show that about 4% of individual patients in detoxification account for 24% of the readmissions.

The "loopers" are absorbing a disproportionate amount of resources which could be better used by those more amenable to treatment, Dr Richman adds.

He recommends "social detoxification" for these alcoholics. It involves provision of a supportive environment in which alcoholics are eased through withdrawal without medication, but with close supervision and reassurance by trained staff. If complications arise, patients are sent to medical centres.

Staff should ensure that existing community services such as housing, pensions, and social assistance are available to the alcoholic, Dr Richman says.

"An individual's immediate survival needs may be more critical than the drinking problems," he says.

Dr Richman acknowledges there are health officials who believe setting up such a system for alcoholic recidivists is a kind of "therapeutic nihilism." However, the door to rehabilitation is open when the patient is prepared to participate, he explains.

Health officials also can't deny that this type of alcoholic exists and that alternatives to the normal treatment procedures are needed, Dr Richman adds.

In a Nova Scotia detoxification study, Dr Richman and others examined 3,221 alcoholics who were first detoxified in any specialized treatment service from 1977-79 and followed them to the end of 1980.

Within two months, 30.2% had entered rehabilitation; by one year that percentage had only risen to 35.8%, Dr Richman says. The proportion of people first entering rehabilitation after each detoxification progressively decreased from 29.7% the first time to 15.1% the fourth time.

"There is no doubt a significant minority of patients are recidivists," he says.

Name change adds clarity says agency

WASHINGTON — What's in a name? A lot when half of it is usually dropped.

Thus, the American Council on Marijuana and Other Psychoactive Drugs is now the American Council for Drug Education.

"We feel the new name is much more descriptive of what we do and what our mandate is," explains Lee Dogoloff, executive director.

Dogoloff

"People often asked us if we were for or against marijuana; they didn't know about the 'other psychoactive drugs.' This clears up that issue as well.

Mr Dogoloff said the council is following its successful conference on cocaine in Santa Monica, Ca, last year (**The Journal** July, Aug, 82) with one in San Francisco, October 5 to 6, which will concentrate on treating cocaine abusers.

Final plans are being made for a conference in Washington on substance abuse in industry.

FEATURE

The New Teen Titans combatting drug use comic-book style

By Harvey McConnell

WASHINGTON — A special edition of a popular comic book is being distributed to United States grade 4 students as part of President Ronald Reagan's administration's efforts to involve the private sector in drug abuse awareness programs for young people.

As the comic book was unveiled at a White House press conference, a nationwide survey noted grade school students report substantial peer pressure to try alcohol and drugs as early as the fourth grade (8 to 10 years).

Carlton Turner, PhD, director of the White House Drug Abuse Policy Office, said additional education programs are being developed by the IBM (International Business Machines) company for grade 5 students, and by the National Soft Drink Bottling Association for grade 6 students.

All the projects are part of long-term drug education and prevention programs, as well as the administration's drive "to inculcate into the private sector the desire to use their expertise and knowledge to help raise the issue of drug abuse awareness throughout the country," Dr Turner said.

The comic book is based on the New Teen Titans and was developed by DC Comics and the Keebler Company for nationwide distribution, along with a classroom poster, a teacher's guide, and a certificate for the students taking part.

Merv Wolfman, who created the Teen Titans in 1980 with artist George Perez, talked to young people being treated at centres in Washington before starting to write the story.

He said he was amazed by the long list of drugs they mentioned and had to limit them in the story to make it credible. He has tried to weave into an adventure story a middle-of-the-road portrayal of what can happen to those who use drugs.

Jenette Kahn, president and publisher of DC Comics, said the comic is aimed at fourth graders who are not drug users: "It would be naive to think we could get the heavy users off drugs."

A Keebler official had no idea of the cost of the campaign; that is not a consideration.

Terry Borton, PhD, editor of Xerox Education Publications, reported on findings of a readership poll among grade 4 to grade 12 students carried out by their classroom publication, *Weekly Reader*. The survey was done in cooperation with Dr Turner's office; the Alcohol, Drug Abuse and Mental Health Administration; the Johnson Institute; and the National Federation of Parents for Drug Free Youth.

A random sample of 100,000 students out of the 500,000 who responded was selected, analyzed, and then weighed to adjust for population distribution.

Dr Borton stressed that the students were not asked about their own drug use, because the information was collected through their teachers, but rather what they believed to be happening to their peers. Results should be treated as indicative of general trends rather than as precise statistics.

Dr Borton said they found "young people are feeling significant pressure to use drugs and alcohol; they don't perceive the school as being a major source of information about the dangers of drugs; they do perceive there is a fairly significant risk in using either alcohol or marijuana."

Teen Titans: the pressure 'to fit in with the other kids' starts to mount as early as grade 4

Starting at grade 4 there is pressure, "and that pressure builds very steadily through the grades. It appears if you want to get these kids where the pressure is least, you have to get to them early. There is a lot of concern among kids but also a lot of feeling of pressure to join in and fit in with the crowd," Dr Borton said.

Grade 4 and 5 students say they learn most about the dangers of drugs and drinking from family and television or the movies. From grade 7 up, school is the most important source of information.

From grade 4 through high school, "other kids" become an increasingly important influence in making drinking and using drugs seem like fun.

While marijuana is considered a drug by approximately 90% of the students, only some 40% consider alcohol a drug, and only around 20% consider cigarettes a drug.

"Feeling older" and "fitting in with other kids" are the major reasons children in grades 4 through 7 believe their peers start using alcohol.

By high school, the major reason the students give for alcohol use is "having a good time."

Students in all grades believe "fitting in with other kids" is why others start to use marijuana.

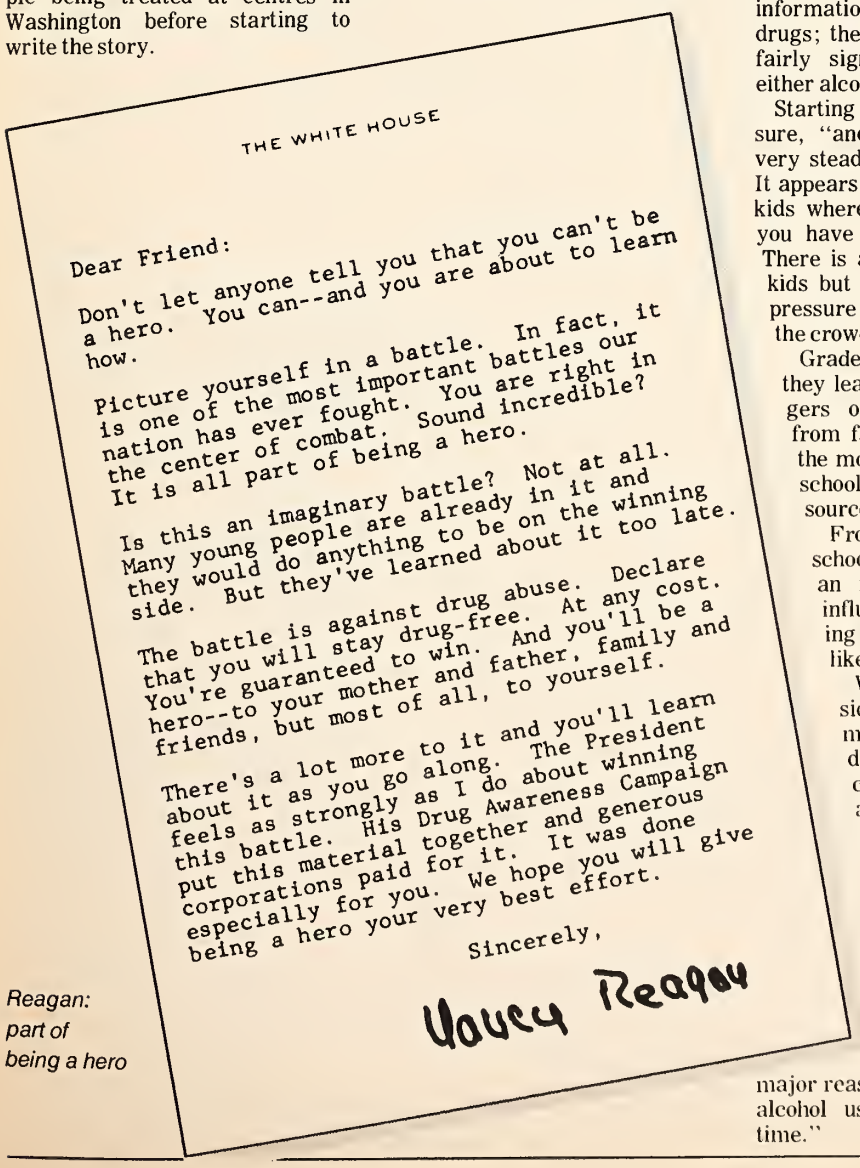
Most of the students consider their peers risk harming themselves if they have a daily drink or smoke a marijuana cigarette daily, although marijuana is seen as the greater risk.

Approximately 33% of those in grades 4 through 8 believe drinking is "a big problem" among those their own age, and 40% say the same thing about drugs. The belief is much higher among high school students.

Most fourth grade students believe some young people their age, in their town, have tried alcohol, and 50% think some have tried marijuana. More than 90% of high school students believe this to be true.

Dr Borton said the students reported on what they believe to be happening. Other studies have shown that actual use of these drugs is not this high, even among high school seniors.

"But the fact that young students think drug use is so common, is, in itself, cause for concern, since our survey shows also that many kids use drugs to 'fit in,'" he said.



THE WHITE HOUSE

Dear Friend:

Don't let anyone tell you that you can't be a hero. You can--and you are about to learn how.

Picture yourself in a battle. In fact, it is one of the most important battles our nation has ever fought. You are right in the center of combat. Sound incredible? It is all part of being a hero.

Is this an imaginary battle? Not at all. Many young people are already in it and they would do anything to be on the winning side. But they've learned about it too late.

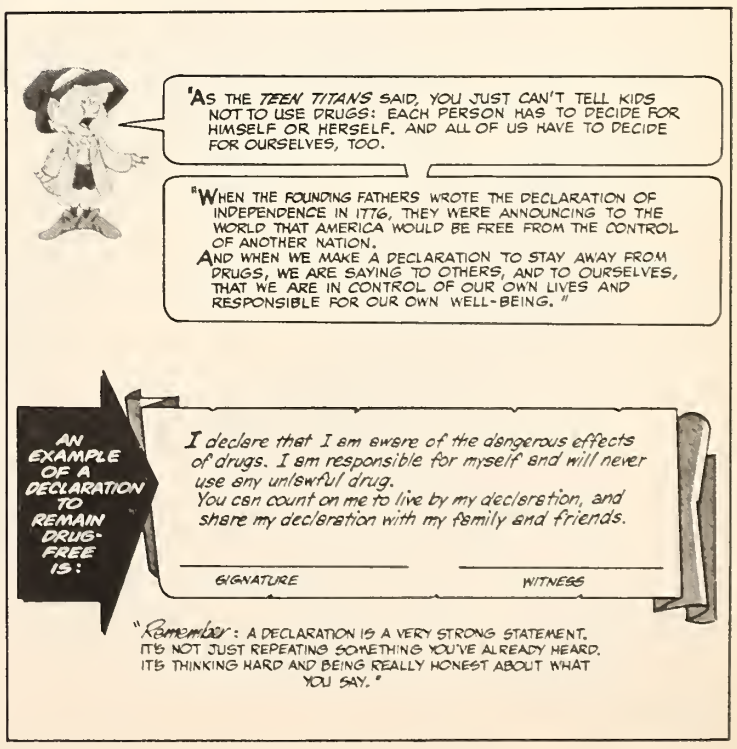
The battle is against drug abuse. Declare that you will stay drug-free. At any cost. You're guaranteed to win. And you'll be a hero--to your mother and father, family and friends, but most of all, to yourself.

There's a lot more to it and you'll learn about it as you go along. The President feels as strongly as I do about winning this battle. His Drug Awareness Campaign put this material together and generous corporations paid for it. It was done especially for you. We hope you will give being a hero your very best effort.

Sincerely,

Nancy Reagan

Reagan: part of being a hero



Declaration: young readers urged to take a stand

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

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Enforcement may be problem

Smoke-booths good idea

Three cheers for the British Safety Council and their proposal that smokers smoke in special booths installed in public places (**The Journal**, April). In light of the research being reported in your newspaper and others about the dangers of second-hand or side-stream smoke, such a plan would indeed cause rejoicing among non-smokers.

The booths (particularly if they were closed off), would be a welcome addition to public places and ensure that we non-smokers can enjoy what fresh air there is in places such as trains.

But the council's strongest argument for the idea is the need to reduce fire hazards in public places. The statistics quoted were alarming; they alone should be enough justification for some crackdown on smokers.

However, I fear the council's ideas probably will go up in smoke. First of all, the cost of installing such booths or special areas may be prohibitive. How many non-smokers will be willing to shell out their tax dollars so that their smoking friends can have a special place to practise their habit?

If the idea does come to fruition, I would hope it would be at the expense of the smokers who could pay for it through an extra tax on their cigarettes. Or, perhaps such an added tax would be better spent on non-smoking and preventive programs.

Secondly, I doubt that many people, smokers and non-smokers alike, will take kindly to the idea of smoking booths in private homes. Unless everyone is to have them installed, how would such a rule be enforced?

Still, the council is to be congratulated for trying to solve the problem of second-hand smoke and still keep everyone happy. Please keep readers posted on any new developments.

T L Higgs
Chester, PA

Alcohol and the brain

I am requesting the references on Dr Ernest Noble's article Alcohol and the brain, (**The Journal**, March).

In addition, I wonder if a complete version of Dr Noble's paper is available for review. If so, I would appreciate the opportunity to receive this as well.

Thank you for your offer of these references.

Eric R Nicely
Program Director
Adult Inpatient Program
The Toledo Hospital
Alcoholism Treatment Center
Toledo, Ohio

•

I read **The Journal** from front to back pages upon receipt of each issue. Can you please send me an extra copy of Dr Ernest Noble's Back Page article, Alcohol and the brain (**The Journal**, March).

The **Journal** is of great value to me. All the best for the future.

Allen A Nield
Communications Consultant
Scarborough, Ont

•

I read with great interest the Back Page article, Alcohol and the brain (**The Journal**, March). I would greatly appreciate your sending me references. Thank you for this.

Brian Scott
University of Windsor
Windsor, Ont

TJ articles keep reader up to date

I got a note from your circulation manager with regard to updating the mailing list. Since I want to keep receiving **The Journal**, I am not sending any note back to them.

The note did, however, raise the issue of a wish to thank you for **The Journal**, which, even though I have not been primarily involved with treatment of addictions, I have found very useful.

Your articles on the field of dependency and drug usage have helped me to keep relatively up to date with what is going on.

Again, a sincere thank you —and keep up the good work.

J A Ward, MD
Sudbury Algoma Hospital
Sudbury, Ont

BC parents join against drugs

I read the article, Teens and Drugs: Parents Grapple With Prevention (**The Journal**, Apr). There are many concerned parents in this community also grappling with the issue of prevention. The parents have turned to this agency in seeking direction. Would you please forward to me the address of the group that recently formed in Toronto, Parents Against Drugs? As well, any other relevant material and/or addresses regarding parent support groups and grassroots anti-drug groups would be appreciated.

Susan Norlund
Director of Services
Out-patient Counsellor
Mackenzie Counselling Services
Mackenzie, BC

The Journal **welcomes Letters to the Editor. Letters bearing the full name and address of sender may be sent to:** The Journal, **33 Russell St, Toronto, Canada M5S 2S1**

COMMENT

Real-world research is perilous

Risks kindle progress

Controlled drinking for alcoholics was a major topic of discussion at the recent meeting of the United States National Council on Alcoholism (NCA) in Houston, Texas.

A plenary session, The Perils of Clinical Research, featured Dr Mary Pendery, PhD, who presented her work which significantly differs from the favorable outcomes on Individualized Behavior Therapy reported by Drs Mark and Linda Sobell, PhDs. (See page 1, and also, The Journal, Dec, Oct, Aug, 1982.)

Barry Tuchfeld, PhD, accepted the invitation to speak to the NCA because, he told The Journal, "I wanted to bring some sanity and perspective on this one issue (of controlled drinking), that, while important, has been taken out of perspective."

Dr Tuchfeld is director, Center for Organizational Research and Evaluation Studies, and associate professor of sociology at Texas Christian University, Fort Worth. In addition, he was the 1981 recipient of the Mark Keller award from the Rutgers Center for Alcohol Studies for his contributions to the alcoholism literature.

The Journal presents Dr Tuchfeld's comments in synopsized form.

One way to view progress in alcoholism research over the last 20 to 30 years is that we know more today about what we don't know.

There are perils and pitfalls in conducting alcoholism research in applied settings — that is, non-laboratory research such as treatment evaluations and epidemiology.

Some of my fellow sociologists like to say that conducting applied research is really best characterized as conducting research in a chaotic and hostile environment — the real world.

I thank Dr Pendery for her research efforts, which provide a foundation on which I hope to construct a larger frame. That frame would allow us to view some of the research progress in a field where systematic research, when compared to chemistry or physics, for instance, is a very recent phenomenon and one in which very little money has been invested.

Let me acknowledge the efforts of the Sobells, too. Without their efforts and those of other behavioral scientists exploring risky and consequential issues, Dr Pendery might not be here today.

I have said there is not sufficient scientific evidence to warrant a policy justifying controlled drinking for alcoholics. Now, to be true to the scientific spirit, I have further explained that this does not say that it never occurs in some people.

There are parallels in other fields. Recently, some scientists have been trying to understand why birds fly in formation. Whatever the scientists' motivations, they have reached a conclusion about why some birds fly in formation. And they have done this mostly through non-laboratory, non-experimental research. Their current position is that it is a complex happening, and that no explanation is yet adequate to explain the problem. This is not to say that it doesn't happen or that it can't be understood. It's simply that they have not yet unravelled the solution.

Even so, they have accomplished several things. They have developed better ways to measure the problem. They have identified new variables and new ideas they didn't have when they began researching the question, they also know more about what they don't know.

The same can be said for alcoholism research. In 1959 Marty Mann discussed three goals of this field. The first was to communicate to the public that alcoholism was a medical disease. Second, that it could be treated and that the alcoholic was worth treating. Third, we had to continue to learn more about this problem and how to improve treatment.

To me, this means we have to work first to overcome the problems and pitfalls in doing research. There are going to be a lot of errors involved, and things may be more often wrong than right. In addition to overcoming practical problems of doing research, we have to continue to share ideas and information. We have to recognize that all of us share the common goal of contributing to the understanding of how to engage constructively that most destructive phenomenon — alcoholism.

I want to highlight what I view as some of the most consequential problems in non-laboratory research. Some have been alluded to in terms of practical, technical problems of implementing a random assignment process, or of doing follow-up — particularly if you are interested in large numbers.

The two most consequential problems in non-laboratory research apply both to treatment research and evaluation, and to epidemiological research about the extent and nature of alcohol problems.

It would be easy to bemoan the practical problems of incomplete data sets, harrassed interviewers, uncooperative respondents, and data that do not always satisfy the technical assumptions of advanced statistical analyses. However, broader issues are of more concern to me.

Not only must we have good measures, but we must also have good questions. Are we asking the right questions? Do we have appropriate expectations of what we can expect from non-laboratory research? Do we recognize that research can give information, but the decisions are ultimately based on human judgements, flawed as they may be by ideology, bias, and politics?

Measurement is the most essential element of research. It requires clearly defined concepts.

In alcoholism research, this means more than classifying a person as an alcoholic or as a social drinker. It means we must be able to measure the degree of the problem, be it medical, psychological, or sociological. Although we are

Tuchfeld: the right questions

beginning to have a standardized basis of criteria, the reality is that except in gross measures of black and white, we have not developed measures that are consistently reliable and valid. In the absence of such measures we must view research findings cautiously, particularly when they endorse our conventional wisdom.

Research and non-laboratory research must continually confront what we call rival hypotheses. We do not have the illusion of control of the laboratory researcher. In treatment outcome research particularly, is effectiveness attributable to the treatment, or to previous or subsequent treatment? Is the fellowship of Alcoholics Anonymous effective because of the 12 steps or because the person has aged out of the problem?

Finally, my concern is with the expectations that we all may have about systematic research in applied settings. What can all of these studies tell us? And what can't they tell us? It is my view that our culture wants scientists to tell us the answers. The goal of these attempts to understand phenomena in the field of alcoholism, particularly in non-laboratory treatment and epidemiological research, is to help reduce uncertainty. We want information that can be used for decision-making.

The consumer often does not understand that even the most liberal interpretation of the philosophy of science does not permit the conclusion that science proves anything. What we can do is provide sound information, and we can specify some probabilities with that information on which better human judgements might be made — as fallible as those human judgements may still be.

Given the youth of our research on treatment and epidemiology, I feel strongly that we must be prepared to continue to research previously unexplored areas. By doing this, we can further our informed basis for decision-making and begin to isolate key variables which justify intensive experiments within acceptable bounds of risks and ethics.

Much is to be said about the persistence and commitment of the alcoholism constituencies in supporting our struggles to evaluate alcoholism treatment and recovery processes, to do clinical and broad-based epidemiological research.

While at times we seem to be spending more time fighting and tearing than building a knowledge base, we are, in fact, moving toward Marty Mann's goals. We are gaining more and more information that sometimes contributes to reducing uncertainty. In the process, we are asking more questions which help us to learn more about what we don't know. From my perspective that is progress.

To ask questions and to seek answers is to take risks. You may get answers you would rather not hear. But even with what appear to be fierce debates, there is a type of tolerance that is developing. It is the tolerance of considering and exploring ideas — not as exclusively limited by our values and ideology as they once may have been. And we must be even more sensitive to where science ends and ideology begins.

But controversial subjects like controlled drinking are considered. And, agree or disagree, you may have heard something that raises a question that, before now, you might not want to have considered. A seed may have been planted.

There is a quotation which says: "Behold the turtle. It makes progress only with its neck out."

The Sobells took risks. Mary Pendery has taken risks. History tells us that this is what's involved as we try to learn.

Alehouse arias of an arresting nature

By Wayne Howell

According to a recent report, a British opera organization is about to launch a "Pints and Puccini" program in Manchester. The plan is to introduce opera into workingmen's pubs, in an effort to create greater interest in opera and to counteract its elitist image.

"Pints and Puccini" may be good for opera (as an opera lover I hope it is) but will it be good for the patrons of the pubs, whose drinking habits have caused no little concern of late?

Imagine, if you will, a group of Manchester workingmen sitting down to their pints of Watney's Red Barrel, only to be assaulted by the oom . . . pah . . . pah beat of Verdi's *La Traviata* and this invitation from Alfredo, the tenor:

Libiamo ne' lieti calici
Che la bellezza infiora,
E la fuggevol ora
S'inebrii a voluttà . . .
(Drink from the joyful glass/Resplendent with beauty/Drink to the spirit of pleasure/Which enchants the fleeting moment . . .)

Will not the Manchester men rise — as do the guests at Alfredo's party — and, glass in hand, respond just as enthusiastically (in Italian of course):

Ah! Godiam — la tazza e il cantico
La notte abbella e il riso;
In questo paradiso
Ne scopra il nuovo di . . .
(Ah! Be carefree — for wine and song/With laughter, embellish the night/The new day, breaking, will find us still/In this happy paradise.)

Needless to say, these are not the kinds of sentiments of which the recent secret government report on alcohol use in the UK approves. Driving home in a state of happy paradise while the new day is breaking can lead to all sorts of complications. Of course, the operas of Giuseppe Verdi (Joe Green) are the product of Italian opera's romantic age. But would Italian *verismo* (true to life) opera be any better?

Imagine, if you will, a group of Midlands workingmen sipping on their Double Diamond between turns at the dart board. Suddenly, the publican cranks up the amplifier and assails them with the *intermezzo* from *Cavalleria Resticana*. As the *intermezzo* fades away, the Double Diamond sippers hear the men from an Italian village coming out of the church where they have just celebrated Sunday morning mass. Softly they sing:

A casa, a casa, amiche, ove ci aspettano
I nostri sposi, andiam . . .
(Let's go home friends/Let's hurry home /Where our wives await us.)

But waiting for these thoughtful family men is Turridu, the tenor, who has something else in mind even though it is not yet noon:
Amici, qua, beviamone un bicchiere
(Friends, let's drink a glass together)

He sings a little aria just to get the workingmen into the spirit of things:

Viva il vino spumeggiante
Nel bicciere scintillante
Come il riso dell'amante
Mite infond il giubilo . . .

(Here is to sparkling wine/In glittering glasses/Wine that awakens joy/Like a lover's laughter.)

And the village men, ostensibly homeward bound, respond:
Beviam! Rinnoviso la giostra!
Viva il vino spumeggiante . . .
(Let's drink!/Let's fill again!/Here is to the sparkling wine . . .)

So much for those waiting wives. And so much for the dart game in the Midlands pub. The fired-up Manchester men replenish their foaming pints and launch into one of Joe Green's greatest hits, *Otello* (Othello), the tenors among them taking the role of Cassio, the baritones Iago:
Come wet your whistle!
Drink hard, drink deep . . .
This true nectar
Of the vine
Clouds the mind
With beautiful mists . . .
The world throbs when I am lit
I defy the ironic gods and fate . . .
Like a harmonious lute I vibrate
Pleasure cavorts in my path . . .

They sing this in Italian of course. Then, vibrating like harmonious lutes, they grab their car keys and head out into the throbbing world, to see what fate, or the ironic gods, or the local constable has in store for them.

Of course, these scenarios are all based on the assumption that "Pints and Puccini" is true to its name and features Italian opera. It may be that the sponsoring organization decides to take a more prudent course and offers the pub-drinkers of the English Midlands something less alcohol-oriented. German opera, for instance. Apart from repeated references to drugs that inflame sexual passions, it's pretty tame stuff.

INTERNATIONAL

Only one in 10 addicts registered

UK admits narcotic problem 'out of control'

By Alan Massam

LONDON — Secretary of State for Health Norman Fowler has admitted the number of narcotic drug addicts in Britain is ten times larger than the number actually registered with the Home Office.

Official recognition of the true scale of the problem came in the House of Commons when Mr Fowler announced new guidelines for projects under the government's recently-announced £6 million ($11,640,000 Cdn) initiative to help drug abusers.

Mr Fowler: "The number of narcotic drug addicts known by the Home Office to be receiving drugs in 1972 was 1,620, but by 1982 the figure had risen to 4,400.

"But these figures relate only to known narcotic addicts. The true figure for drug misuse is much higher and must take into account people who are dependent on other types of drugs. Research suggests there could be as many as 40,000," said Mr Fowler (**The Journal**, Jan.)

Mr Fowler's public acknowledgement will be welcomed by field workers who have been saying the same thing for years. It discounts the official view, often stated in the past, that the British system of dealing with heroin abuse (in which the drug is prescribed to addicts at government-sponsored clinics) keeps the situation under control because the majority of addicts make themselves known to obtain supplies.

The situation, particularly in London now, is that vast quantities of illicit heroin are entering Britain — as the ever-increasing scale of customs seizures indicates (**The Journal**, Feb).

The fact the government is devoting £6 million to addiction problems — at a time when public money is scarce even for more politically-popular causes — also indicates concern that the escalating drug abuse problem is reaching panic proportions.

Mr Fowler said he hoped health and local authorities would give urgent consideration to the problem and cooperate in producing responses. "I see some of the money going on more facilities, like walk-in centres for those addicts not presently going for treatment," he said.

Hostels, half-way houses, and rehabilitation centres in the community, and the recruitment of staff to help addicts, would also be favorably viewed, he said.

Local and health authorities and voluntary organizations will have to apply for grants.

The £6 million is intended as a pump-priming operation and will cover a three-year period. Objectives include: providing regional and local assessments of the nature and spread of drug misuse; helping professionals to tackle the problem; improving links between various agencies trying to cope; and ensuring the services for addicts are providing value for money.

Script drugs now feed Piccadilly area

Gone are cannabis, LSD, heroin

By John Ingalsbe

LONDON — The popular Piccadilly/Haymarket area here has been a major drug market since the early 1960s, but a recent study has found few illicitly imported or manufactured drugs now change hands in the area.

The study, published in the *British Journal of Addiction* (March), found instead that a pharmaceutical drug scene is flourishing there. It is fed in large part by an "overspill" from "scripts" (daily maintenance dosage) issued by government-run Drug Dependency Units (DDUs), the National Health Service (NHS), and from private doctors.

Cannabis, LSD, and powdered heroin are generally not for sale in the area, the study says.

Piccadilly: individual entrepreneurs dealing in small amount of drugs — usually from legal sources

Angela Burr, PhD, a member of the Addiction Research Unit of London's Institute of Psychiatry, conducted the study. She says it would be almost impossible to break up the pharmaceutical drug scene because of its unusual dealing structure and the overflow of drugs from clinics. But she says much more could be done to control "lax prescribing."

In the mid-1960s Piccadilly became an outlet for pharmaceutical drugs when a large number of them flooded the illicit market because of over-prescribing by a handful of doctors, the study reports.

With the advent of DDUs in 1968, an illicit, powdered-heroin market developed in the area. However, when cheaper, hard-drug sources became available elsewhere in the city during the 1970s, Piccadilly once again became a pharmaceutical drug scene.

Few studies have been done on the area, Dr Burr says. She undertook to define the size and shape of the drug market by observing and making personal contact with dealers and users over a 14-month period (Dec, 1979 to Feb, 1981).

Dr Burr admits it was difficult to determine exactly how many dealers were selling part of their DDU scripts, primarily because many were reluctant to reveal their sources. A conservative estimate would be never fewer than 20 per day, she says.

Most of the injectible Physeptone (methadone)and the occasional pharmaceutical heroin sold in the area appeared to be overspill from DDU scripts and private doctors, the study says. Most of the non-opiate drugs came from prescriptions obtained from the NHS and, occasionally, doctors. Some users bragged of having scripts from several doctors at once.

The study found that a very small proportion of drugs were illicitly manufactured. Some drugs were also obtained through thefts from pharmacies, clinics, or manufacturers.

The study found the main drugs on sale in the area are: 100 mg Tuinal (amylobarbitone sodium and quinal barbitone) two for £1 (£1 equals Cdn $1.94); 10 mg Ritalin tablets (methylphenidate) £2.50 each; 40 mg Diconal (cyclizine hydrochloride and dipipanone hydrochloride) £4 each; 100 mg Nembutal capsules (pentobarbitone pentobarbital/sodium) two for £1; 250 mg Doriden tablets (glutethimide) price varies; and 10 mg Physeptone injectable ampoules (methadone or methadone mix) at £6 each.

Unlike illicit, powdered-heroin dealing, which involves an "intricately interrelated hierarchical pyramid-shaped social structure," the pharmaceutical scene is made up of individual entrepreneurs dealing in small amounts usually obtained from his or her own legal source(s). With each drug user competing with the other, the scene is chaotic, the study says.

British teens responding to war on tobacco

By Alan Massam

LONDON — Health educators here see a recent Cancer Research Campaign survey of young people's smoking habits as the most important indicator yet that the battle against tobacco is being won.

Anne Charlton of Manchester sent 20,000 questionnaires to schools in Cumbria, and Tyne and Wear, North England, with 15,709 responses from young people aged eight to 20 years.

The survey — the biggest ever conducted in the UK — found that 17% of both boys and girls are regular smokers.

In the 16 to 19 years age group, 26% smoke compared to 43% and 39% for boys and girls respectively in a 1972 survey.

In the 11 to 13 years age group, 4% of boys and 2.5% of girls smoke at least once a week, whereas a 1975 survey showed 8% of boys and 5% of girls in that age group had started smoking.

Dr Charlton: "The answers indicate that health warnings about smoking are being acted upon."

Nonetheless, the latest UK survey found, for example, that 1% of the sample had tried a cigarette by age four and 20% by age nine. Boys tended to experiment with cigarettes earlier than girls but fewer went on to be regular smokers. Between the ages of 13 and 16 years, more girls than boys reported being regular smokers.

Stores were most frequently the source of cigarettes for regular smokers — even for boys and girls under 16 years (for whom the sale of tobacco products is illegal), whereas experimental smokers usually got their cigarettes from friends.

Family members, teachers, and friends influenced smoking behavior. If one parent smoked, the young person was 6% more likely to have started the habit. If father, mother, or teacher disapproved of smoking, however, the young person was 33% to 42% less likely to be a regular smoker.

Only 3% were regular smokers if they thought their best friends disapproved of the habit.

Even at this early age, ill effects of smoking were being noticed; young people smoking six or more cigarettes a week reported frequent coughs.

Dr Charlton told **The Journal** that smoking in Britain is now considered to be linked with 1,000 premature deaths per week. "Adults can make their own decisions, but it is obviously important to educate children about the habit, which obviously starts early in life."

She said the survey results will be used to evaluate new health education approaches to the tobacco problem.

* *Cancer Research Campaign, 2 Carlton House Terrace, London SW1Y 5AR.*

Cig sales drop but ASH fights on

LONDON — The British tobacco industry has acknowledged that sales of its products are falling — much to the delight of health educators. The number of cigarettes sold declined by 7.5% last year, following a drop of 9% in 1981.

The Royal College of Physicians pressure group ASH (Action on Smoking and Health) said the two-year drop would eventually reduce by a substantial proportion the current level of premature deaths annually from smoking.

Professor Peter Sleight, chairman of ASH and professor of cardiovascular medicine at the University of Oxford, said: "This is tremendous news. A decline of 15% in cigarette consumption will mean a major reduction in suffering and premature deaths."

ASH is not giving up the battle, however. When it was later announced that a major tobacco company had received a Queen's Award for Industry, ASH director David Simpson said: "This is downright immoral. To be awarded for exporting this uniquely damaging product is about as sick as you can get. It is like a rabid dog being given a prize at Crufts (Britain's top dog show).

"Cigarettes are quite simply a disaster. They cause at least 50,000 premature deaths a year, which is seven times the figure for road accidents. They are always dangerous rather than just being dangerous when abused.

"Now that the smoking epidemic is at last being beaten here the cigarette barons are stepping up their efforts to sell their wretched products abroad, particularly to the unsuspecting and highly vulnerable nations of The Third World."

It was no surprise, Mr Simpson added, that the developing nations were now on course to follow Britain as future world leaders in lung cancer, bronchitis, and heart attacks.

Mr Simpson: "They have quite enough health problems already and they just cannot understand how our society can allow the encouragement to tobacco manufacturers to infect them with the disastrous habit of smoking.

"It is obvious that this sort of cynical and unethical nonsense will continue until Parliament passes a wide-ranging tobacco act, binding all government departments to pull together to eradicate the smoking problem — and prevent its export to other countries."

INTERNATIONAL

Britain gets new breath tester, tougher laws

By Alan Massam

LONDON — There is every indication the British government intends to get tougher with the drinking driver.

As of May 6, changes in the law will, in the words of the department of transport, "make it easier for the police to process cases and . . . close loopholes which previously allowed suspects (of drinking and driving) to escape conviction on legal technicalities."

Police have been equipped with a new, faster method of measuring the concentration of alcohol in the body — breath testing. They are using a breath alcohol concentration (BrAC) limit, expressed as 35 micrograms of alcohol in 100 millilitres of breath, measured by electronic breath-testing machines. The machines, known as "evidential" breath testers, replace blood or urine tests for alcohol concentrations.

More controversial is the introduction of new police powers allowing the arrest of people who have been driving or in charge of a vehicle as well as those caught in the act. "This will prevent drivers evading the law by, for example, running away from the vehicle," a department of transport spokesman explained.

Moreover, the police are now entitled to follow a driver to his home or some other "refuge" and enter, by force if necessary, to arrest him. Such powers already exist in Scotland, where drinking and driving are a greater problem.

The police may also force entry, if necessary, to the home or refuge of an individual who has had an accident involving injury to a third party, to perform the breath test.

And they may also breath-test a suspect whom they believe *intends* to drive or take charge of a vehicle (rather than one already in charge of the vehicle) and use a portable electronic breath-tester at the roadside.

A spokesman for the department of transport said the breath alcohol concentration of 35 micrograms of alcohol in 100 ml of breath did not change the prescribed alcohol limit used previously of 0.08% or 80 mg of alcohol per 100 ml of blood.

The suspect would normally be asked to provide two breath samples and only the lower result would be used as evidence. Any suspect whose BrAC did not exceed 50 micrograms could request a blood or urine test.

Otherwise, blood or urine tests will no longer be used unless the suspect has medical contraindications to the breath test, such as asthma, or if an approved evidential breath-testing machine or trained operator are not available.

Another legal loophole now closed is the "hip flask defence" commonly used by regular drinkers who claimed they had taken a drink (from a hip flask) after an incident to steady the nerves. Now, they will have to prove they consumed alcohol after ceasing to drive, and that the amount consumed was capable of raising the body alcohol above the permitted level.

The department of transport also intends to crack down on so-called "persistent offenders." About 3,000 of the 57,000 drivers found above the legal limit each year are "problem drinkers" who had been disqualified twice within a 10-year period and had more than 2½ times the legal limit of body alcohol when arrested.

In future, these drivers will have to submit to medical examination to prove the problem has been effectively treated or cured before being allowed to drive again.

Third World economy, health at stake

UN agencies face off on tobacco

By Thomas Land

ROME — A conflict over investment in tobacco cultivation around the hungry belt of the globe threatens to explode into a public controversy between two United Nations organizations wielding immense influence over development planning in agriculture and public health.

Delicate diplomatic manoeuvres are now taking place to avert a row between the sister agencies, the UN's Food and Agriculture Organization (FAO) based here, and the World Health Organization (WHO) in Geneva. But confrontation seems inevitable at the Fifth World Conference on Smoking and Health, to be held in Winnipeg, Canada, in July when the opposing policies will be argued.

The FAO has been reluctant to condemn all tobacco cultivation in the developing regions because of its apparent short-term profitability. But for the WHO, any advance against smoking is crucial to the organization's long-term commitment to the establishment of reasonable global health care standards by the turn of the century.

The two agencies recently reached a tenuous compromise at a private meeting in Geneva, described by one participant as "frank . . . revealing considerable differences of approach to the problem and reflecting very different constituencies."

Seeking to turn its opponent into an ally, the WHO has asked the FAO to study the social as well as economic effects of tobacco cultivation in the Third World. The FAO report has just been published. It concludes that "until world demand — which was still rising in 1977 to 1980 — can be curbed sufficiently to make tobacco growing less profitable, it will be very difficult to induce growers to curtail production."

A recent issue of *Ceres*, the journal of the FAO, elaborates that, "as an important source of employment and cash income in all the countries where it is grown, tobacco provides rural work, industrial employment, and national income. It is a lot more than just smoke in the economy of many countries."

Tobacco is grown in about 120 countries. Both its production and consumption have recently increased substantially in the developing regions, reducing the United States' share of the world market for unmanufactured leaves to 19% in 1979 to 1981 from 25% in the early 1960s. In Zimbabwe, tobacco earns almost a quarter of the national agricultural income; in Malawi, it earns about 8% of the cash income of all farmers.

Ceres says: "Tobacco is, in fact, one commodity in which even smaller developing countries can find immediate, tangible, social and economic benefits."

But the FAO challenge has been anticipated by the WHO. Kurt Baumgartner, secretary-general of the forthcoming world conference and executive director of the Canadian Council on Smoking and Health, warns developing countries that they may have to face a smoking epidemic within a generation.

In a recent issue of *World Health*, the WHO journal, Mr Baumgartner says: "As smoking is becoming increasingly a minority habit in the Western World, the multinational tobacco companies have found new outlets in the developing countries. Many Third World countries have welcomed the new 'prosperity' that tobacco has brought, they have even provided economic incentives to attract these companies.

"By contrast with North America and Europe, in many developing nations the tobacco manufacturers are free to advertise their wares without legal restrictions. So the Third World has become a dumping ground for cigarettes with high tar and nicotine contents whose sale is not permitted elsewhere." (**The Journal**, Feb, 1982.)

The WHO considers that the control of cigarette smoking in the developing countries "could do more to improve health and prolong life . . . than any other single action in the whole field of preventative medicine".

An expert committee of the organization fears that increased cigarette consumption could undermine current achievements in the developing regions in nutrition, sanitation, and the control of infectious diseases.

The Canadian organizers of the world conference have already decided to make the role of the tobacco industry in the developing countries an important subject of discussion. They may have thus set the stage for an historic confrontation.

Sun-curing tobacco: many countries welcome the new prosperity but health workers are worried FAO

Tobacco: grown in 120 countries

Few nations are seeking ILO help to develop drug rehab programs

By Berouz Shahandeh

VIENNA — The International Labour Organization (ILO) wants to help in world drug control efforts, but few countries are seeking aid from the agency, says Ed Sackstein, ILO drug rehabilitation specialist.

"Only a very small number of countries have sought assistance," he told the United Nations Commission on Narcotic Drugs in Vienna.

This despite the obvious need to "develop viable rehabilitation services in those countries that are struggling with problems of drug consumption," he said.

Employment is crucial in the rehabilitation and social reintegration of ex-addicts, Mr Sackstein told **The Journal**. It gives them "a certain identity and a place in society."

And special assistance is needed for them to overcome the difficulties of re-entry. Vocational rehabilitation, including vocational evaluation, job counselling and guidance, job preparation, training, placement, and follow-up, specifically addresses these problems.

While Mr Sackstein believes most countries are "deeply concerned" about increasing drug abuse problems, the needs of drug dependent people are given "remarkably low priority."

He said this is particularly surprising in view of the adoption two years ago by the UN of an international strategy and policies for drug control which emphasize a balanced and concurrent reduction of supply and demand.

Rehabilitation can play a major role in demand reduction, he said, by providing vocational and social assistance required for adapting again to the community.

He said it is necessary to develop and implement rehabilitation programs paying special consideration to local requirements in each country. In such planning, maximum use must be made of existing resources.

Governments, said Mr Sackstein, should not approach planning of rehabilitation programs in terms of show case or "model" vocational training centres but rather with the aim of pulling together, into a coordinated program, the facilities and resources already operating in these countries.

Mr Sackstein criticized the practice in some countries where "institutions can often serve as society's dust bin for problem or troublesome groups."

Institutions "isolate and therefore segregate" addicts, forcing them to lose contact with family, friends, jobs, and so on. Although such separations are necessary sometimes, they should be kept to a minimum. In the period of re-entry to the community, social support systems play a significant role.

Mr Sackstein stressed the need for community participation embracing public and private organizations, voluntary groups, and concerned individuals in generating a better understanding of addicts' problems and changing negative attitudes.

Addicts' greatest handicap is the attitude of others to them; it leads to "job discrimination, social isolation, reinforced negative self-image, and reduced access to services which are available to the general public."

He stressed the need to end the practice in which drug-dependent people are "mere customers of services." Instead, they should be trained to develop "social survival skills," and be encouraged to undertake activities beneficial to the community.

Mr Sackstein said the ILO will continue to contribute to the international drug program. Among its immediate projects is the first Latin America seminar on the vocational and social re-integration of drug-dependent youth which was scheduled to be held last month in San Jose, Costa Rica with the financial assistance of the UN Fund for Drug Abuse Control.

The ILO will also be preparing a drug rehabilitation handbook for government planners and professionals in a variety of related fields. The document will describe the state of the art and focus on identifying basic problem areas with a view to guiding others in planning their own strategy, policies, and programs.

NEWS

No evidence of widespread abuse, says study

Benzodiazepine use down

TORONTO — Contrary to much recent publicity, benzodiazepines are not widely abused and are completely safe and effective, says the chairman of a large Canadian family medicine department.

Walter Rosser, chairman of the University of Ottawa family medicine department, outlined a recent survey of benzodiazepine use at the annual meeting of the College of Family Physicians of Canada.

Using a computerized registry system, Dr Rosser studied the prescribing rates for oxazepam, diazepam, flurazepam, chlordiazepoxide, and lorazepam, drugs accounting for more than 95% of benzodiazepine prescriptions at the Ottawa Civic Hospital Family Medicine Centre in 1982.

During 1982, there was an average of 12,716 patients aged 15 years and older registered in the practice, Dr Rosser said, 3.2% of whom (410 patients) received 742 prescriptions for the drugs.

An average of 80% of the drugs prescribed had a short half-life. Dr Rosser said this followed a significant trend over the past few years toward the widespread use of short-acting benzodiazepines.

Twenty-one patients, 17 females and four males, were identified as heavy users of benzodiazepines, receiving more than two units of equivalence daily in 1982. Dr Rosser defined one unit of equivalence as being equal to 5 mg of diazepam, 15 mg of oxazepam, 25 mg of chlordiazepoxide, 1 mg of lorazepam, or 15 mg of flurazepam.

The mean age of males in this group was 50.3 years and of females, 64.5 years. All of these patients had poor social supports, Dr Rosser said, with the women noted as suffering from many symptoms related to high levels of anxiety.

Dr Rosser said there has been a 15% to 30% decline in the overall prescribing of the drugs at the Ottawa centre during the past four years.

He said while women continue to receive more of these types of drugs than men, "there is a significant shift away from middle-aged women to women more than 65 years as recipients of the most benzodiazepines."

The fact that only 5% of benzodiazepine recipients were found to be taking two or more units of the drugs daily supported observations made in other countries that "only a small proportion of people can be classed as abusers or heavy users," Dr Rosser said.

Dr Rosser said only four of the 21 individuals were heavy enough users of benzodiazepines to be identified as being likely to suffer significant withdrawal symptoms.

"One might add that it is questionable that someone using two units of equivalence each day for one year is an abuser of the medication."

He said that "current knowledge of the safety of these drugs suggests that the present level of concern amongst the population about abuse and misuse of these drugs cannot be justified."

Dr Rosser added that drug companies have informally reported a 25% decline in benzodiazepine sales in the past four years.

"One would hope that physicians who adopt a policy of never prescribing benzodiazepines in their practice can be convinced to reconsider . . .

"Such policy deprives patients of a safer method of effectively controlling symptoms of acute anxiety than commonly-used and readily-available alternatives," Dr Rosser said, mentioning alcohol, tobacco and ASA (acetylsalicylic acid) as examples.

"There is no evidence of widespread abuse of these drugs and even among those who heavily use benzodiazepines for prolonged periods of time there is no evidence of risk of serious withdrawal reactions or mental or physical deterioration," Dr Rosser concluded.

'Profile' may aid US drug arrests

WASHINGTON — The United States Supreme Court has given approval for police and airport officials to stop those who fit a "drug courier profile" but the judgment limits the questioning that can then ensue.

The nine justices did not reach a majority view. Five different opinions were handed down, although in essence eight of the justices agreed that law enforcement officials may stop a traveller fitting the profile.

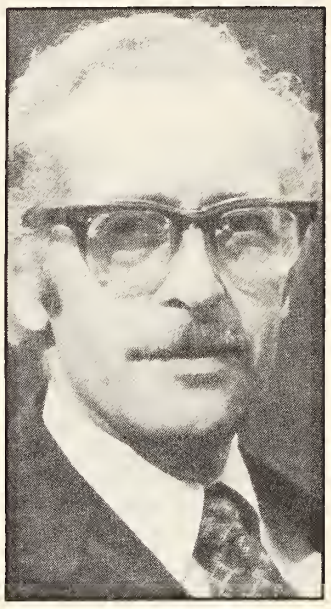
The profile was pioneered by the US Drug Enforcement Administration (DEA) and consists of a number of behavioral characteristics believed to be exhibited by people trafficking in drugs. These include such things as the way people stand around looking nervous, whether the plane ticket has been paid in cash with a large number of bills, or if the name but no address appears on luggage identification tags.

The justices decided, however, that there must be a limit on questioning. Police action amounting to an arrest, followed by the discovery of drugs, is not permitted, the court decided.

Research society honors Kalant's long-term work

TORONTO — Harold Kalant of the Addiction Research Foundation (ARF) here has received the fourth annual research award from the Research Society on Alcoholism.

Dr Kalant, associate research director and head of the biobehavioral studies department at the ARF, was presented with a plaque and cheque recently at the society's annual meeting in Houston, Texas.



Kalant: career contribution

The society, which has members in Canada, the United States, and Mexico, gives the award each year for career contribution in alcohol research. Dr Kalant was recognized for his long-term work on the conceptualization of alcohol tolerance and physical dependence.

Dr Kalant, who is also a professor of pharmacology at the University of Toronto and an editorial board member of The Journal, received the Raleigh Hills Foundation Gold Medal in 1981; in 1972, he received the Jellinek Foundation award for his contribution to alcohol research.

Last year's research society award winner was T. K. Li, a professor of biochemistry at the University of Indiana medical school, for his career work on genetic predisposition to alcohol tolerance.

Union, management join to celebrate EAP effort

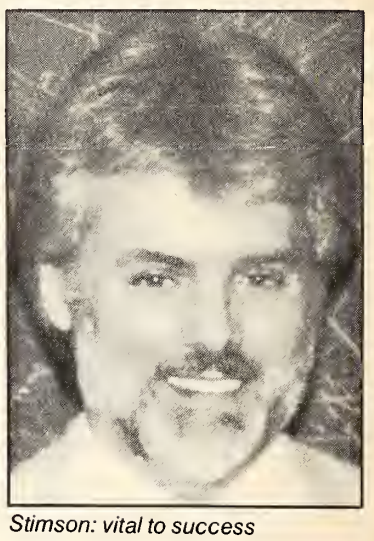
VANCOUVER — Management and union representatives here have joined forces to recognize the achievement of an employee assistance program (EAP) coordinator for Canada's largest forest products company.

Jim Stimson received the award from the British Columbia Industrial Relations Management Association (IRMA) for his efforts in establishing the EAP and for his role in launching the South Vancouver Island Alcohol and Drug Assessment and Referral Centre.

This centre offers treatment assistance to employees of all companies in the South Vancouver Island region.

Mr Stimson, of MacMillan Bloedel, was nominated for the award by representatives of both management and union. It was the first union nomination ever received by the IRMA for this award.

"There's no question that outstanding cooperation between union and management people has been a vital part of our success so far," says Mr Stimson.



Stimson: vital to success

"By putting aside the usual adversary positions, we've been able to work together to solve real human problems that affect people's lives both on and off the job."

The annual IRMA award is presented for "outstanding achievement in human relations work." Mr Stimson was nominated for his "personal commitment to the concept of employee assistance and his dedication to making it work."

UK police chiefs want pipeline to dealers' assets

LONDON — Britain's chiefs of police have called on the government to emulate the United States and confiscate all the assets of convicted drug traffickers. (**The Journal**, Dec, Mar, 1982).

This was recommended at the annual meeting of the Association of Chief Police Officers. They want the courts to have the power to seize assets automatically.

The police chiefs also called for British police liaison officers to be based in Western Europe, especially Amsterdam, one of the main drug trafficking centres in Western Europe.

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High level negotiator helps force change: Blume

By Lynn Payer

NEW YORK — A cabinet-level commissioner of alcoholism at state level can be "tremendously helpful" in getting legislation passed and obtaining budget and other needs, says Sheila Blume, MD.

Yet it appears only a few states have such a position, says the former director of the New York State Division of Alcoholism and Alcohol Abuse.

"I found that people were interested in what we were doing once I was able to talk to them. The interest was there," Dr Blume told **The Journal**.

"But, in government, you need a motivating factor," said Dr Blume, who left the state position recently to become medical director of the United States National Council on Alcoholism (NCA).

During Dr Blume's term in office, a number of laws relating to alcoholism were passed: changing drunk-driving laws; allowing confidential early intervention programs for impaired physicians; raising the minimum age for purchase of alcohol to 19 from 18 years; permitting young people to be treated for alcohol abuse without parental consent; removing discriminatory provisions of New York State civil service law in hiring recovered alcoholics; modifying insurance laws to cover alcoholism; and changing the legal definition of child neglect to encourage appropriate alcoholism treatment for parents.

Blume: why bother?

Dr Blume said prior to the change in the definition of child neglect, alcoholic mothers were often not referred for appropriate treatment because a diagnosis of alcoholism was considered *a priori* evidence of child neglect.

For those seeking changes in alcohol legislation, Dr Blume had this advice: "I learned toward the end of my four years that when you're backing a change, or a piece of legislation, you must prepare a carefully-thought-out document that summarizes what you want to do, with the pros and the cons and the evidence. Other people just can't absorb and keep everything that you're saying."

Dr Blume became interested in alcoholism in 1962 when, as a resident in psychiatry, she was put in charge of a women's unit of a psychiatric hospital.

"From my background of psychiatric training I felt I needed to talk to each patient for an hour."

As this was impossible, "I picked the one who was sickest, and the one I judged the least sick. The one I had judged the sickest had acute psychosis and did very well — the hospital was built for psychotics. The one I had judged least sick turned out to be an alcoholic teacher with six or seven children.

"I floundered around trying to find ways to help her and finally approached my supervisor, whose response was 'Why bother?' That response essentially changed my whole career."

As medical director of the NCA, Dr Blume sees her role as helping the council in its role as consumer advocate.

"We're not a provider of alcoholism services and we don't do research. We're a national voice to look out for the alcoholic, or the person with alcoholism in the family."

Dr Blume, who has been particularly interested in the problems of women alcoholics since her supervisor asked her 'Why bother?' suggested more attention should be paid to multiply-disabled alcoholics and the children of alcoholics.

She also urged workers in alcoholism not to lose sight of the public intoxicant.

"They may only be a few percent of the whole, but they include some very sick people. Sometimes the term 'revolving door' is used in a pejorative sense, but these periodic sobering-ups and periods of care are life-saving. I hate to see people criticized as revolving door purveyors; even if it's not long-term rehabilitation, it's a humane, life-saving role."

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

You Bet Your Life

Number: 556.
Subject heading: Gambling.
Details: 12 min, 16 mm, color.
Synopsis: Many people are so addicted to gambling that, as with Frank, they lose everything — home, family, job. For Frank, the high he gets from gambling is like being on drugs and, as with drug addiction, treatment is required to help those addicted.
General evaluation: Good (4.0). This contemporary film was judged a good general information film on what happens to people who become addicted to gambling. General broadcast was recommended.
Recommended use: General adult audiences.

Up in Smoke

Number: 557.
Subject heading: Smoking.
Details: Four filmstrips, four cassette tapes; 70 min each.
Synopsis: Four filmstrips entitled: 1) How Smoking Affects Your Health; 2) Why Do People Smoke?; 3) How Smoking Affects Your Health (Part II); 4) Breaking The Habit, explain the health costs of smoking and why it is such a difficult habit to break. A great deal of historical information is also presented.
General evaluation: Fair to good (3.5). These filmstrips were judged contemporary and full of good information. However, some members felt they portrayed quitting as being more difficult than it really is.
Recommended use: Of benefit to audiences eight to 18 years.

Straight Talk About Drugs: Tranquillizers and Sedatives

Number: 558.
Subject heading: Drugs and youth, drug use: epidemiology and pharmacology.
Details: Four filmstrips, four cassette tapes, 10 min, each.
Synopsis: Four filmstrips discuss the use and abuse of tranquillizers and sedatives. The titles of the filmstrips are: 1) An overview; 2) Tranquillizers; 3) Sedatives I; 4) Sedatives II.
General evaluation: Fair (3.3). These contemporary filmstrips were full of good information. However, they seemed to imply that moderate use of tranquillizers and sedatives is the only way of coping with some problems — non-use is not considered as an alternative.
Recommended use: With a resource person this series could benefit those 12 years and older.

Lots of Kids Like Us

Number: 554.
Subject heading: Alcohol and the family.
Details: 28 min, 16 mm, video, color.
Synopsis: Ben, a 10-year-old boy, is attending summer day-camp. He is withdrawn, shy, and the counsellors have difficulty trying to get him to participate in group activities. Ben's father has an alcohol problem, and Ben does not know how to deal with the problems that are being caused in his family. Conrad, an outgoing camper, whose mother was an alcoholic, tries to befriend Ben. Conrad has been through many experiences with his mother and offers Ben good advice on coping and taking care of his younger sister. Eventually Ben seems able to understand and begins to take positive action.
General evaluation: Good to very good, (4.6). This contemporary, well-produced film was judged a good teaching aid that could help young people deal with alcohol problems in the family. General broadcast was recommended.
Recommended use: With a resource person the film would benefit children 8 to 12 years, camp counsellors, and parents.

DEPARTMENT

New Books by RON HALL

Smoking and Reproduction: A Comprehensive Bibliography

. . . compiled by Ernest L. Abel

This bibliography of 1,232 citations lists various titles relating to tobacco and its effects on reproduction. The volume is a comprehensive but by no means exhaustive compilation of the world literature on the subject. Many citations not originally in English have been referenced as they appeared and have been translated. The introductory chapter includes information on tobacco; its chemistry and pharmacology; effects on sexual behavior, function, and physiology; spontaneous abortion; birthweight; neonatal mortality; long-term effects of maternal smoking; and sudden infant death syndrome.

(Greenwood Press, 88 Post Rd, PO Box 5007, Westport, CT 06881. 1982. 163 p. $35. ISBN 0-313-23663-1)

Substance Abuse Book Review Index 1981

. . . by Jane Bemko

For this third edition, some 328 journals have been scanned on a regular basis for reviews of books on the topic. The full citations for 239 books are presented and the citations of the reviewing journals are noted for each book. This series is intended for librarians, acquisition departments, or anyone interested in reading reviews before purchasing books. The index has been found useful in locating and reviewing books on particular subjects; and authors and publishers have found it helpful in locating reviews of their own publications. While the title of a particular book may be repeated in different editions of the *Index*, there is no duplication of listed reviews from year to year.

(Addiction Research Foundation, Marketing Services, 33 Russell St, Toronto, ON M5S 2S1. 1982. 58 p. $6.95. ISBN 0-88868-074-0)

Directory of Alcohol and Drug Treatment Resources in Ontario 1983

. . . edited by Catherine Blake

This update of the *Directory* includes 28 new agencies to bring the total to more than 250 treatment programs and resources. Each addiction-specific program has been described independently whether or not it is part of a larger organization. Program descriptions are arranged in the main body by geographic region, and within each section in alphabetical order. These descriptions provide information on location, hours of service, funding arrangements, client population, nature of service, and a description of the alcohol or drug specific program. The directory is indexed by program name, treatment type, services for special populations, and special focus.

(Addiction Research Foundation, Marketing Services, 33 Russell St, Toronto, ON M5S 2S1. 1983. 402 p. $29.95. ISBN 0-88868-075-9)

The Encyclopedia of Alcoholism

. . . by Robert O'Brien and Morris Chafetz

This work treats the subject in a dictionary format with articles ranging in length from a few to several thousand words. It covers all aspects of alcoholism — biological, medical, and psychological areas, social and economic effects, legal implications, terminology used in treatment, slang, organizations that deal with alcoholism, various theories on the cause, and the extent of alcohol abuse in different nations and what these nations have tried to do about controlling it. Myth and lore are explored and distinguished from fact. Introductory material describes alcohol as a substance and traces the evolution and development of alcoholic beverages from earliest times to the present day, showing man's changing attitudes toward alcohol throughout history. It is intended as a reference work on alcohol abuse for members of the medical profession, social workers, legal firms, concerned organizations, and the layman.

(Facts on File Publications, 460 Park Ave S, New York, NY 10016. 1982. 378 p. $40. ISBN 0-87196-623-9)

Other Books

Confronting Alcohol Problems in Your Congregation — Adams, Bob H. CompCare Publications, Minneapolis, 1982. Guidelines for clergy to recognize and aid alcoholics in their congregations. 20 p. CompCare Publications, 2415 Annapolis Ln, Minneapolis, MN 55441. $1.50. ISBN 0-89668-054-8.

Etiologic Aspects of Alcohol and Drug Use — Gottheil, Edward; Druley, Keith A.; Skoloda, Thomas E.; and Waxman, Howard M. (eds). Charles C. Thomas, Springfield, 1983. Biological factors; psychological factors; sociocultural factors; papers presented at the 4th Coatesville-Jefferson Conference on Addiction, 1980. Index. 330 p. Charles C. Thomas, 2600 S First St, Springfield, IL 62717. $39.95. ISBN 0-398-04732-4.

Marty Mann's New Primer on Alcoholism — Mann, Marty. Holt, Rinehart and Winston, New York, 1981. How people drink, how to recognize alcoholics, and what to do about them; first published 1950. 239 p. Holt, Rinehart and Winston, 383 Madison Ave, New York, NY 10017. ISBN 0-03-059157-0.

Marty Mann Answers Questions About Drinking and Alcoholism — Mann, Marty. Holt, Rinehart and Winston, New York, 1981. Myths and misconceptions; symptoms; women alcoholics; denial; approaches to the alcoholic; treatment; Alcoholics Anonymous. 113 p. Holt, Rinehart and Winston, 383 Madison Ave, New York, NY 10017. ISBN 0-03-059156-2.

Alcohol and Industrial Accidents — Argyropoulos-Grisanos, M.A., and Hawkins, P.J.L. Christian Economic and Social Research Foundation, London, 1981. Statistics on industrial accidents; experiments; performance measurements; personality factors. 52 p. Christian Economic and Research Foundation, 12 Caxton St, London SW1H 0QS. £2.50.

Agenda for Action on Alcohol — Blake, George Thompson. Christian Economic and Social Research Foundation, London, 1981. Medical, social, family, and industrial aspects; drinking and driving; alcohol and crime; impact of advertising; temperance; education. 32 p. Christian Economic and Social Research Foundation, 12 Caxton St, London SW1H 0QS. 50 pence. ISBN 0-905651-07-3.

Legislative Action to Combat the World Smoking Epidemic —Roemer, Ruth. World Health Organization (WHO), Geneva, 1982. Action by the WHO; role and evolution of legislation; analysis of legislation; restrictions on smoking in public areas and in the workplace; prevention; economic measures. Appendices. 131 p. Canadian Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, ON K1Z 8N8. ISBN 92-4-156074-6.

Take the Time, II — Yoast, Richard A. Wisconsin Clearinghouse, Madison, 1981. Alternative activities for self-discovery, exploration, adventure; vignettes. 47 p. Wisconsin Clearinghouse, 1954 E Washington Ave, Madison, WI 53704. $2.50.

Compulsive Overeater — B., Bill. CompCare Publications, Minneapolis, 1981. Step-by-step program for compulsive overeaters; modelled on Alcoholics Anonymous. 287 p. CompCare Publications, 2415 Annapolis Ln, Ste 140, Minneapolis, MN 55441. $10.95. ISBN 0-89638-046-7.

Alcoholism and Homosexuality — Ziebold, Thomas O. and Mongeon, John E. (eds). Haworth Press, New York, 1982. Theoretical perspective; clinical problems; treatment options; new approaches that are being implemented are analyzed; programs and treatment protocols are described. Index. 107 p. Haworth Press, 28 E 22nd St, New York, NY 10010. ISBN 0-917724-93-3.

Financial Resource Management for Nonprofit Organizations — Haller, Leon. Prentice-Hall, Englewood Cliffs, 1982. Significance and potential of small, non-profit organizations; planning and budget formulation; managerial operations and issues; economic enterprises; governance. Index. 191 p. Prentice-Hall, Englewood Cliffs, NJ 07632. $8.95. ISBN 0-13-316299-0.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Annual Meeting of the Canadian Lung Association — June 5-8, Halifax, Nova Scotia. Information: Doris Goodwin, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, Ontario K1P 5E7.

3rd Annual Summer School on Addictions — June 19-24, Charlottetown, Prince Edward Island. Information: The department of Extension and Summer Sessions, University of Prince Edward Island, Charlottetown, PEI C1A 4P3.

Up-Date In Analytical Biochemistry — June 22-25, Toronto, Ontario. Information: Continuing Medical Education, Faculty of Medicine, Room 245, Fitzgerald Building, University of Toronto, ON M5S 1A8.

25th Annual Meeting of the American Association for the Study of Headache — June 25-26, Toronto, Ontario. Information: Executive Director, Seymour Diamond, 5252 N Western Ave, Chicago, Illinois 60625.

Canada Safety Council 15th Annual Safety Conference — June 26-29, Moncton, New Brunswick. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, Ontario K1G 3V4.

Canadian Association of Health, Physical Education and Recreation 50th Anniversary Conference — June 26-29, Toronto, Ontario. Information: Russ Kisby, c/o Participaction, 80 Richmond St W, Ste 805, Toronto, ON M5A 2A4.

Cannabis Consequences for Canadians — June 28, Toronto, Ontario. Information: George W. Peck, vice-principal, Sir William Osler Vocational School, 1050 Huntingwood Dr, Agincourt, ON M1S 3H5.

Fifth World Conference on Smoking and Health — July 10-15, Winnipeg, Manitoba. Information: Fifth World Conference on Smoking and Health, PO Box 228, Station B, Ottawa, Ontario K1P 6C4.

24th Annual Institute on Addiction Studies — July 17-22, Hamilton, Ontario. Information: Alcohol and Drug Concerns Incorporated, 15 Gervais Dr, Ste 603, Don Mills, ON M3C 1Y8.

Summer Course in Addictions (Fundamental Concepts) — July 18-21, Toronto, Ontario. Information: Barbara MacPherson, Administrative Coordinator, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

The Annual Conference of the Canadian Mental Health Association — Aug 3-6, St John's, Newfoundland. Information: Dr Edna Turpin Downey, Canadian Mental Health Association, Newfoundland Division, PO Box 5788, St John's, NF A1C 5X3.

International Doctors in Alcoholics Anonymous Annual Meeting —Aug 4-7, Vancouver, British Columbia. Information: Dr Lewis Reed, IDAA Secretary, 1950 Volney Rd, Youngstown, Ohio 44511.

5th Biennial Canadian Conference on Employee Assistance Programs, Input '83 — Aug 9-12, Toronto, Ontario. Information: Input '83 Headquarters, Professional and Management Development, Humber College, Box 1900, Rexdale, ON M9W 5L7.

Canadian Society of Forensic Science 1983 Annual Conference — Aug 13-19, Vancouver, British Columbia. Information: Joanne Cottingham, Executive Secretary, Canadian Society of Forensic Science, Ste 303, 171 Nepean St, Ottawa, ON K2P 0B4.

Modern Granulation, Tabletting, and Capsule Technology — Aug 22-25, Toronto, Ontario. Information: General Information, PO Box H, East Brunswick, New Jersey 08816-0257.

2nd World Conference on Prison Health Care — Aug 28-31, Ottawa, Ontario. Information: Congress Secretariat, Medical Services Branch, The Correctional Service of Canada, Ottawa, ON K1A 0P9.

Royal College of Physicians and Surgeons Annual Meeting — Sept 19-22, Calgary, Alberta. Information: Robert A. Davis, associate director, Office of Fellowship Affairs, Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

Ontario Chapter College of Family Physicians of Canada 21st Annual Scientific and Business Meeting — Oct 2-5, Toronto, Ontario. Information: Ontario Chapter College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

1984 Canadian Addictions Foundation Atlantic Regional Conference, Families and Drug Dependencies New Problems, New Challenges — Apr 29-May 3, 1984, Halifax, Nova Scotia. Information: Nova Scotia Commission on Drug Dependency, 5668 South St, Halifax, NS B3J 1A6.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: Mr J Skirrow, chairman, 34th ICAA Congress, AADAC, 6th Floor, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

Cocaine: The Costly High —June 11-12, Los Angeles, California. Information: Health Sciences UCLA Extension, PO Box 24901, Los Angeles, CA 90024.

45th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 13-15, Lexington, Kentucky. Information: Dr Joseph Cochin, executive secretary, Boston University School of Medicine, 80 E Concord St, Boston, Massachusetts 02118.

5th Regional Conference (Eastern) of the Association of Labor Management Administrators and Consultants on Alcoholism: Meeting the Challenge of the '80s — June 15-18, Parsippany, New Jersey. Information: Denise Sijack, Publicity Chairperson, 114 Prospect St, Passaic, NJ 07055.

University of Utah School of Alcoholism and Other Drug Dependencies — June 19-24, Salt Lake City, Utah. Information: University of Utah School of Alcoholism and Other Drug Dependencies, PO Box 2604, Salt Lake City, UT 84110.

Support Group Facilitator Training Seminar — June 20-24, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

34th Annual Symposium on Alcoholism — Alcoholism and the Family — June 20-July 1, Seattle, Washington. Information: Alcohol Studies program, Seattle University, Seattle, WA 98122.

Alcoholism in the Workplace — June 21-23, Boston, Massachusetts. Information: Office of Continuing Education, Harvard School of Public Health, 677 Huntington Ave, Boston, MA 02115.

12th Annual San Diego Summer Alcohol and Drug Studies Program — July 10-15, San Diego, California. Information: UCSD Extension, X-001, University of California, San Diego, La Jolla, CA 92093.

9th Annual Summer School on Chemical Dependency — July 10-22, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

Children of Alcohol/Drug-Dependent Parents — July 11-12, Indianapolis, Indiana. Information: Kay Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Alcohol/Drug Counselling Skills I — July 11-15, Center City, Minnesota. Information: Marilyn Brissett, Continuing Education department, Hazelden Foundation, Center City, MN 55012.

Joint Commission on Accreditation of Hospitals — Alcoholism Clinical and Treatment Planning Requirements Workshop — July 13-15, Philadelphia, Pennsylvania. Information: The National Association of Alcoholism Treatment Programs, Inc, 2082 Michelson Dr, #200, Irvine, California 92715.

World Congress on Mental Health — July 22-28, Washington, DC. Information: World Federation for Mental Health, #107-2352 Health Sciences Mall, University of British Columbia, Vancouver, British Columbia V6T 1W5.

Chemical Dependency and Family Recovery — July 25-29, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

New Jersey Summer School of Alcohol and Drug Abuse Studies — July 31-Aug 5, New Brunswick, New Jersey. Information: Gail Gleason Milgram, Education and Training Division, Center of Alcohol Studies, Smithers Hall, Rutgers University, New Brunswick, NJ 08903.

National Association of Alcoholism and Drug Abuse Counselors (NAADAC) Conference — Aug 7-10, Houston, Texas. Information: David W. Oughton, National Association of Alcoholism and Drug Abuse Counselors, 951 South George Mason Dr, Ste 204, Arlington, Virginia 22204.

7th Annual Summer Institute of Drug Dependence — Aug 14-19, Colorado Springs, Colorado. Information: Dan Barmettler, director, The Institute for Integral Development, PO Box 2172, Colorado Springs, CO 80901.

Family Program For Professionals — Aug 15-19, Sept 19-23, Oct 17-21, Nov 28-Dec 2, Center City, Minnesota. Information: Marilyn Brissett, Continuing Education department, Hazelden Foundation, Center City, MN 55012.

Strategic Planning and Marketing For Substance Abuse Services — Aug 16-18, Cambridge, Massachusetts. Information: Management Division, Lesley College Graduate School, 1627 Massachusetts Ave, Cambridge, MA 02138.

Prevention-Outlook for the '80s — Aug 18-20, Myrtle Beach, South Carolina. Information: Cathy McKinney, Charlotte Drug Education Center, 1416 Morehead St, Charlotte, North Carolina 28204.

Alcohol and Drug Problems Association of North America 34th Annual Meeting — Aug 28-Sept 1, Washington, DC. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

7th Annual Summer Institute on Drug Dependence — Aug 28-Sept 2, Colorado Springs, Colorado. Information: Dan Barmettler, Institute for Integral Development, PO Box 2172, Colorado Springs, CO 80901.

Alcohol/Drug Counselling Skills II — Aug 29-Sept 2, Center City, Minnesota. Information: Marilyn Brissett, Continuing Education department, Hazelden Foundation, Center City, MN 55012.

Drug and Alcohol Issues Symposium — Sept 14-16, Dayton, Ohio. Information: Thomas Prugh, WORAC, 379 W First St, Ste 300, Dayton, OH 45402.

2nd Annual Conference of the National Federation of Parents for Drug-Free Youth — Sept 26-28, Washington, DC. Information: National Federation of Parents for Drug-Free Youth, 1820 Franwall Ave, Ste 16, Silver Spring, Maryland 20902.

12th Annual meeting of the Association of Labor Management Administrators and Consultants on Alcoholism — Oct 3-7, Minneapolis, Minnesota. Information: ALMACA, 1800 N Kent St, Ste 907, Rosslyn, Virginia 22209.

Basic Drug Information for Alcohol/Drug Counsellors — Oct 10, Indianapolis, Indiana. Information: Kay Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

American College of Chest Physicians — Oct 23-27, Chicago, Illinois. Information: Executive director A. Soffer, MD, FCCP, 911 Busse Hwy, Park Ridge, IL 60068.

American Association for the Study of Liver Diseases — Nov 4-7, Chicago, Illinois. Information: C. B. Slack, 6900 Gorve Rd, Thorofare, New Jersey 08086.

Innovations In Alcohol/Drug Abuse Programming: Models-Methods-Evaluation — Nov 7-11, Pacific Grove, California. Information: Leslie Nyberg, Evaluation and Research department, Box 11, Center City, Minnesota 55012.

American Society of Criminology 35th Annual Meeting — Nov 9-12, Denver, Colorado. Information: Joseph E. Scott, department of Sociology, Ohio State University, Columbus, Ohio 43210.

1983 ADPA Western Regional Conference — Nov 13-16, Los Angeles, California. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101-15th St, NW, Ste 204, Washington, DC 20005.

Abroad

29th International Institute on the Prevention and Treatment of Alcoholism — June 27-July 2, Zagreb, Yugoslavia. Information: Archer Tongue, International Council on Alcohol and Addictions (ICAA), Case postale 140, 1001 Lausanne, Switzerland.

9th International Conference of the International Association for Accident and Traffic Medicine — July 10-15, Mexico. Information: Dr R. Andreasson, IAATM, PO Box 10043, 5-100 55 Stockholm 10, Sweden.

8th Institute on Drugs, Crime, and Justice in England and America — July 11-15, London, England. Information: Institute on Drugs, Crime and Justice, School of Justice, The American University, Washington, DC 20016.

VII World Congress of Psychiatry — July 11-16, Vienna, Austria. Information: Congress Team International, PO Box 9, A1095 Vienna, Austria.

Australian Medical Society on Alcohol and Drug Related Problems 3rd Annual Conference — July 31-Aug 7, Cairns, North Queensland, Australia. Information: Conference Organizers, PO Box 155, Civic Square, ACT, 2608, Australia.

Middle Eastern Summer Institute on Drug Use (MESIDU): Techniques, Strategies, Concepts and Options — Sept, Jerusalem, Israel. Information: Stan Einstein, PhD, Director, MESIDU, 113/41 East Talpiot, Jerusalem, Israel.

International Conference on Alcoholism — Sept 26-30, Reykjavik, Iceland. Information: ICAA, Case postale 140, 1001 Lausanne, Switzerland.

12th International Congress for Suicide Prevention and Crisis Intervention — Oct 2-5, Caracas, Venezuela. Information: Sociedad Venezolana De Psiquiatria, Apartado Postal, 3380, Caracas 1010A, Venezuela.

13th International Institute on the Prevention and Treatment of Drug Dependence — Oct 10-14, Oslo, Norway. Information: ICAA, Case postale 140, 1001 Lausanne, Switzerland.

8th World Congress of Acupuncture — Oct 12-16, Seoul, Korea. Information: Dr Anton Jayasuriya, secretary, Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

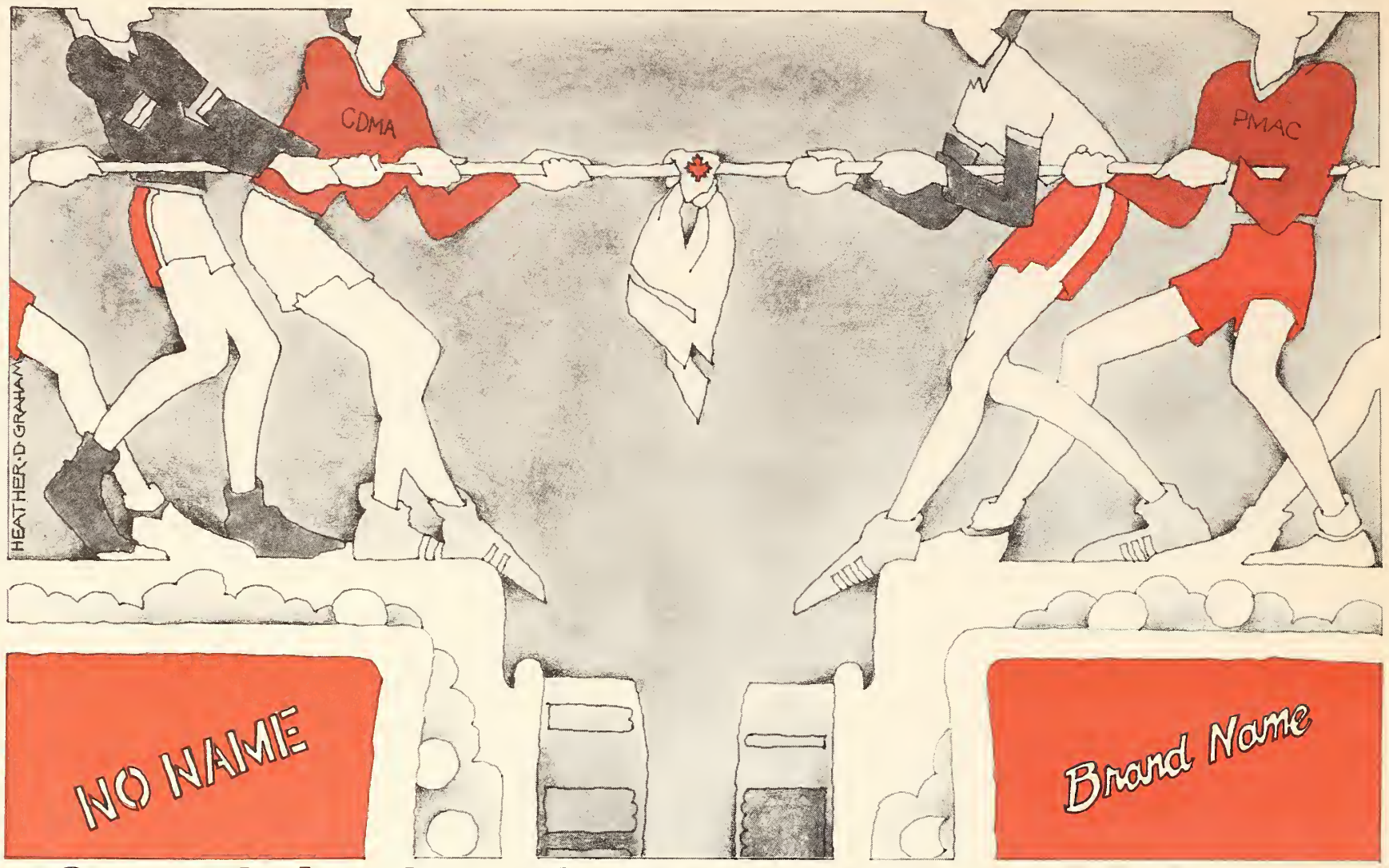
9th International Conference on Alcohol, Drugs and Traffic Safety — Nov 13-18, San Juan, Puerto Rico. Information: T-83 Secretariat, GPO Box 5067, Medical Sciences Campus, San Juan, Puerto Rico 00936.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

2nd International Congress on Drugs and Alcohol — Dec 18-22, Tel Aviv, Israel. Information: Congress Secretariat, Peltours Ltd, Congress department, PO Box 394, Tel Aviv, 61003 Israel.

4th World Congress of Alternative Medicine — July 13-15, 1984, Amsterdam, Netherlands. Information: Dr Anton Jayasuriya, secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: Dr H. D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.



Canada's drug industry at crossroads?

By Incor Jowat

TORONTO — Pressure to change an aspect of pharmaceutical laws in Canada has reached its most intense point in more than a decade. The controversy has far-reaching implications involving millions of dollars and the future direction of the prescription drug industry in this country.

On one side of the battle are 12 Canadian drug companies who produce generic drugs and claim that the large, multinational, research-based pharmaceutical companies are an "international cartel" intent on monopolizing the drug industry and destroying an embryonic Canadian industry.

Pitted against them are the large multinational companies. They maintain the present system is unfair and say if they are not given reasonable patent protection for the drugs they develop, drug research in Canada could dwindle to almost nothing.

Both sides say hundreds of jobs are at stake.

In the middle is the federal government, which is responsible for making the laws and is, among other things, trying to promote industrial research and development in Canada while protecting the consumer from high drug prices.

The whole scenario centres on subsection 41 (4) of the Patent Act, an amendment passed in 1969 which provides for the granting of an automatic licence by the ministry of consumer and corporate affairs to anyone to copy and market drugs almost as soon as they appear on the market.

This compulsory licensing regulation eliminated the usual 17 years of patent protection and was passed following controversy over high drug prices in order to stimulate price competition.

Under the licensing provision, companies operating in Canada have to pay a 4% royalty on sales of the licenced (generic) product to the originating company. But the research-based companies maintain this provision allows the manufacturers of licenced drugs to take advantage of another company's years of work and make a lot of money for an insignificant sum.

By the summer of 1982, 274 compulsory licences had been issued on 30 drug entities, including sedatives and hypnotics. For example, a recent federal publication on benzodiazepines says diazepam is sold as 15 brand-name products and four generics. Chlordiazepoxide may be purchased under 13 separate brand names and six generics, and oxazepam is distributed under three brand names and one generic.

Compounding the situation in the eyes of the large companies is legislation passed by the provinces (still pending in Nova Scotia) in the last decade or so. It allowed or forced pharmacists to substitute less expensive, generic copies of brand-name drugs prescribed on government drug plans.

Lobbying for the two sides is done by the Pharmaceutical Manufacturers Association of Canada (PMAC) and the Canadian Drug Manufacturers Association (CDMA). The PMAC represents 66 companies including the large, multi-national drug companies, while the CDMA is comprised of the 12 Canadian-owned and -operated generic drug companies.

This year has seen major lobbying actions by both groups, with the PMAC advocating a change in the current system keyed on the elimination of compulsory licensing and the CDMA fighting just as adamantly for retention of the current law.

The arguments have been distilled in two briefs; the PMAC's *Proposals for Patent Law Reform in relation to the Compulsory Licensing Provisions under Section 41 of the Patent Act*, and the CDMA's *A Case for the Retention of Section 41(4) of the Patent Act*.

The PMAC brief submitted in February contains proposals for changing the current system: repealing the compulsory licensing provision, establishing a voluntary price monitoring system, and encouraging Canadian research.

The brief says compulsory licensing resulted in "only marginal and temporary reductions" in drug prices and has produced a steady decline in real growth of research and development.

Because of the provision, the brief said, Canada is regarded internationally by the research intensive industry as "an unfavorable environment for investment."

The brief also points out that two of the four companies holding the majority of compulsory licences are United States subsidiaries and are not Canadian-owned, so it is unfair to view the situation as a battle of "us against them."

PMAC spokesman Gordon Postlewaite also said the proposals are not "an anti-generic company" issue because they are not retroactive and would allow the companies to continue to produce drugs currently not under patent protection.

To illustrate how compulsory licensing has hurt the companies, the brief shows how various firms such as Merck Frosst Canada Inc, Hoffman-La Roche Limited, and Ayerst, McKenna and Harrison Inc, have been forced to shelve planned expansions, close down operations, or move to the US.

Following this brief, the CDMA came out swinging with its own brief in April.

The main message given by the CDMA is that Canadians can expect to face exorbitant increases in drug prices if the compulsory licensing provision is removed, and the brief focuses on the apparent savings brought to Canadians by the introduction of generic drugs.

It compares Canadian prices with prices for drugs in the US, where there is no compulsory licensing or provincial (or state) substitution laws.

For example, the brief says that 5 mg tablets of diazepam sell for $3.13 per thousand at the wholesale level in Canada, compared to $187.97 Cdn in the US for the brand-name product. Chlordiazepoxide 10 mg capsules are quoted as selling for $9.91 per thousand wholesale in Canada for the generic product compared to $156.86 Cdn in the US for the brand-name product.

The brief said virtually all western nations, except the US and West Germany, regulate prices and keep them moderate.

"The price of drugs in West Germany and the US are the highest in the world because of lack of effective control," the brief says.

Coinciding with the release of this brief, the CDMA held a news conference to put forward their views.

Leslie Dan, president of Novopharm Ltd and a CDMA director, said generic drug companies help to keep all drug prices lower in Canada, not just those products for which generic counterparts exist.

He said the presence of the generics could be saving Canadians as much as $100 million a year.

Bernard Sherman, PhD, president of Apotex Inc and also a CDMA director, said that if the compulsory licensing provision is repealed, "we estimate the additional cost to Canadians over the next decade would be approximately $5 billion."

The CDMA counters the PMAC argument that research in Canada is dwindling by maintaining that Canada has always been, and is likely to remain, "a branch-plant operation."

The CDMA says while there have been plant closings by drug companies, "what must not be ignored is the far more significant number of new plants and major expansions of existing plants that has taken place during the period of compulsory licensing."

Dr Sherman said the generic companies are committed to producing all drugs in Canada and not just the popular ones when they become large enough, and that they are already involved in researching better methods of manufacturing drugs.

The PMAC points out that while savings might result from having cheap alternatives to popular products, the large companies are left to produce the high cost, low volume, but necessary variety of other drug products.

The CDMA, predictably, has little support for the PMAC proposal and is extremely dubious about the PMAC's commitment to monitor prices voluntarily.

And, the Canadian generic companies say, the full patent protection the multinationals want will result in closer to 25 years of exclusivity than 17 years, because companies often hold a number of patents on a single drug.

The PMAC has answers for most of the CDMA arguments, the most significant being the claim that generic drug companies have not saved Canadian consumers nearly as much money as the CDMA says they have.

At the moment, it appears the PMAC is rallying a good deal of support for a change in the legislation.

The association maintains that 17 separate health and scientific organizations including the Canadian Medical Association, the Chemical Institute of Canada, and the deans of all eight schools of pharmacy in Canada have supported their call for change.

The PMAC also claims support of the provincial governments in Saskatchewan, Alberta, Nova Scotia, Newfoundland, and Quebec.

On their side, the CDMA says the Ontario Pharmacists Association executive committee decided not to support a resolution to change the legislation, and the pharmaceutical associations of British Columbia and Quebec have taken a neutral position.

Although secretive on the issue, the federal government has admitted it is reconsidering the compulsory licensing provision.

But government spokesmen have said this is not a guarantee that any changes in the law will be made.

Most observers agree it will be difficult to reach a decision that will satisfy both sides and still benefit Canadian consumers.

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Prison survey supports link between drugs, crime

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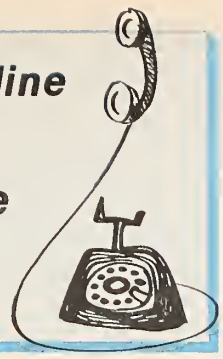
Cocaine helpline shows shift in user profile



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Drug abuse by elderly

Not just the lonely, poor

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The Journal

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Canada attains most votes in bid for UN drug seat

By Mark Kearney

TORONTO — Canada's return as a member of the United Nations' (UN) Commission on Narcotic Drugs — after a four-year absence — could stimulate more interest in reducing worldwide demand for drugs.

This is the opinion of Donald Smith, PhD, former commission chairman, and senior scientist, Intergovernmental and International Affairs, Health and Welfare Canada.

Dr Smith told **The Journal** that Canada is committed to ensuring "all possible approaches are followed" in battling drug abuse. He hopes that in the next four years (the length of Canada's term) the commission will shift some of its focus away from supply reduction to that of reducing demand.

"I don't think there's any resistance (by commission members) to the idea of demand reduction, but we have to demonstrate what can be done. I think we (in Canada) have something to demonstrate," Dr Smith said.

Canada was reinstated to the commission with the most votes (49) at the spring meeting in New York City of the UN Economic and Social Council (ECOSOC). Dr Smith credits strong lobbying and Canada's reputation as "a country interested in social questions" as reasons for its return to membership on the commission.

(Canada, a member of the commission since its inception in 1946 lost its seat in 1979 [**The Journal**, Nov, 1979]. Dr Smith and a team of Canadians have sat as observers to commission meetings since 1980.)

Other members of the Western Europe and Others Group, of which Canada is a member, elected to the commission are: France (48 votes), Greece (47), Austria (45), Finland (45), Federal Republic of Germany (44), United States (44), Italy (40), and the Netherlands (38).

In the commission's Eastern European Group, Hungary and Yugoslavia were elected with one further seat to be filled. Madagascar and Morroco were elected to represent African States with two seats to be filled later. India, Thailand, Pakistan, Sri Lanka, and Iran were elected from the Asian States group. Argentina, Brazil, Colombia, and Peru will represent Latin America. The appointments take effect Jan 1, 1984.

The commission has also expanded its membership from 30 to 40 seats because of strong, worldwide interest in fighting drug abuse, Dr Smith said. The expansion may help intensify the attack on drug problems in the coming years.

The commission is the chief, international, policy-making body in the drug enforcement field. A belief that strict law enforcement was the only answer to combatting drug abuse has become well-entrenched, and today remains the strongest current of thought at the commission.

Smith

However, the Canadian government has programs aimed at reducing demands for drugs, such as tranquillizers and marijuana. Canada is also suggesting that part of the contribution for the UN Fund for Drug Abuse Control be used in a program involving the International Council on Alcohol and Addictions to train workers in Africa in the rehabilitation and treatment of drug addicts, Dr Smith explained.

He added that if Canada continues to show demand reduction can work, it may convince other countries to follow suit.

The problem with this approach, however, is it can take many years to gather data which support the effectiveness of reducing demand for drugs. Nevertheless, Dr Smith believes this policy should be followed at an international level. He added that other recently-elected commission members will be allies in this shift from supply to demand reduction.

The idea of reducing the supply of drugs and the heavy emphasis on enforcement peaked in the early 1960s when a dramatic upsurge of drug abuse was seen in the West. The US believed that if drug supplies could be wiped out, drug abuse in that country would end.

Contaminated meperidine producing parkinsonism

Disease of elderly striking drug abusers

By Mark Rand

SAN DIEGO, CA — Several hundred intravenous drug abusers are believed to have used a contaminated "synthetic heroin" which is capable of producing a syndrome indistinguishable from Parkinson's disease. So far, a dozen cases of the drug-induced parkinsonism have been identified, mainly in the San Francisco area.

William Langston, MD, of Stanford University School of Medicine, Stanford, Cal, presented a paper at the annual meeting of the American Academy of Neurology here and discussed, in an interview with **The Journal**, the 10 cases he has seen so far.

Addicts who had used the drug seemed to have advanced Parkinson's disease on admission to hospital, Dr Langston said. They had a shuffling gait, if they were able to move at all, many had severe tremors, parts of the body were completely rigid, and many were unable to speak.

Parkinson's disease typically strikes people in their 50s and 60s, but the addicts Dr Langston has seen range from 22 to 42 years.

When Dr Langston and colleagues saw their first cases of this kind in July, 1982, the initial diagnosis was "psychogenic catatonia." However, when they tracked down and analyzed the synthetic heroin the addicts had been taking, they found another explanation for the symptoms.

The synthetic heroin, a Demerol (meperidine) analogue called MPPP, contained the contaminant MPTP. This contaminant which is produced when short-cuts are taken in the preparation, is also being investigated at the United States National Institute of Mental Health. (See related story p 2).

MPPP stands for 1-methyl-4 -phenyl-4 -propionoxy-piperidine. MPTP stands for 1-methyl-4-phenyl-1,2,5,6-tetrahydropyridine.

The hospitalized addicts had typically taken 150 mg to 500 mg of MPTP, usually as a 2% or 3% contaminant by weight in the "China White" synthetic heroin they were taking. Some addicts, however, may have been exposed to much higher doses of MPTP, Dr Langston said.

Analysis of samples taken from an illicit lab uncovered in the San Francisco area in 1982 showed that some samples were virtually pure MPTP.

The addicts seen by Dr Langston had typically used MPTP-contaminated drugs several times over a period of a week or two, although some had apparently been exposed to MPTP only once or twice.

Symptoms appeared three to 10 days after the first exposure to MPTP and progressed rapidly.

Dr Langston said the addicts' (See — This — page 2)

Reagan drug policy under fire

By Charles-Gene McDaniel

CHICAGO — Now you see it, now you don't," is the way a leading United States drug abuse professional describes President Ronald Reagan's policy on drug abuse.

"Federal leadership is simply not there, and the president of the United States is playing a 'shell game' with the lives of the nation's young people," he says.

Monsignor William O'Brien, president of Daytop Village in New York City, made the charges here at the 7th World Conference of Therapeutic Communities. Daytop is the oldest, publicly-funded, drug-free treatment agency in the US.

He was joined in his criticism of federal policy by Congressman Charles B. Rangel, a New York Democrat, and Richard Pruss, president of the Therapeutic Communities of America (TCA), and president of Samaritan Village Inc, Forest Hills, NY.

Msgr O'Brien pointed out that since President Reagan took office, the federal budget to combat drug abuse has dropped 33% — to $134 million from $201 million.

"You can't have the 'First Lady', as well-intentioned as she is, going around giving the US public the clear impression that the Reagans care about the victims of drug abuse while her husband is wiping out the treatment services that are so desperately needed," Msgr O'Brien said.

"I am saddened because the families and young people who have already been so brutalized by drugs are now the victims of a White House public relations strategy which puts the 'First Lady' in the precarious position of a 'diplomat without portfolio,' " he added.

Msgr O'Brien noted that other First Ladies have had a significant impact upon federal policy, citing the influence of Rosalyn Carter, who championed the cause of mental health, and 'Lady Bird' Johnson, who successfully promoted conservation.

Reagan

Carter

Johnson

First Ladies: can have a significant impact on US federal policy

(See — Rhetoric — page 2)

INSIDE

NEWS

Narcotic clinical trials set to help resolve heroin use for pain management

By Mark Kearney

OTTAWA — It will be at least two years before a decision is made on whether heroin can be used legally in Canada for chronic pain management, says a Health and Welfare Canada official.

Jean Sattar, media inquiries officer for the health protection branch, says clinical trials are scheduled to start this fall and continue for between one year and 18 months. It will take another six months after that to study the results and report on heroin's effectiveness.

Details of the trials still have to be worked out, but it's expected that several hundred cancer patients across Canada at centres that specialize in cancer treatment will take part, Ms Sattar told **The Journal.**

Henderson

Ian Henderson, MD, director of the bureau of Human Prescription Drugs, visited the centres in June to determine the interest in participating in the trials.

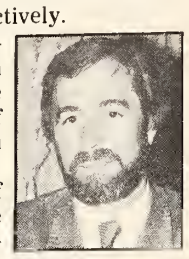
Health Minister Monique Begin announced the trials in May as a way of assisting the Expert Advisory Committee on the Management of Severe Pain in its investigation of the treatments available in Canada. The committee is to produce a monograph on the treatment of pain to be distributed to all Canadian physicians (**The Journal**, March).

"These trials would compare the effectiveness of heroin in pain relief with that of other narcotics, thus providing the committee with data on Canadian experience in the use of heroin," Ms Begin said. "The committee's initial report will be updated when the results of the studies are available.

"I feel it is important for Canadian physicians to receive, as soon as possible, the best expert advice currently available on the management of severe pain. Should heroin prove to have a place in pain therapy, the advice will be updated to reflect the new findings."

Canada banned heroin from all uses, including medical, in 1955 following a World Health Organization directive. However, other countries such as Great Britain use heroin in pain management.

Edward Sellers, MD, is the commitee's chairman and Clinical Institute director of Ontario's Addiction Research Foundation. Dr Sellers, who is also associate professor of medicine and pharmacology at the University of Toronto, told **The Journal** that although he's not directly involved with the trials, one of his tasks is to ensure the committee acts objectively.



Sellers

"It (the committee) has been formed to tackle the task (of studying pain management) and what kind of job we do will be determined after we've done it."

However, Kenneth Walker, MD, author of the syndicated column *The Doctor Game* (under the pseudonym Dr W. Gifford-Jones) believes a delay of two years to study heroin is unreasonable if other countries already use it. Dr Walker last year presented Ms Begin with a petition bearing more than 15,000 signatures supporting the legalization of heroin for medical use in Canada (**The Journal**, Sept, 1982).

He has also established a foundation "to help frustrated Canadians fight" for legalization. Dr Walker told **The Journal** that while he's surprised the government has agreed to the trials, he's concerned that some members of the committee are already biased against the use of heroin before the tests begin.

Both the Canadian Society of Hospital Pharmacists and the Canadian Cancer Society have argued against legalizing heroin, saying it leads to break-ins in hospitals and that the drug would get into the hands of drug addicts.

'This stuff burns when you inject it'

(from page 1)

parkinsonian syndrome was virtually identical to advanced Parkinson's disease. However, while many advanced Parkinson's patients show signs of dementia, the addicts appeared to have fully-intact mental capacities.

The addicts' symptoms can largely be relieved by standard anti-parkisonism medications such as levodopa, Dr Langston said. However, as soon as the dose is decreased or the medication is stopped altogether, the symptoms return in full force within hours.

"These people, it seems, will have no choice but to be on anti-parkinsonian drugs for the rest of their lives," Dr Langston commented. However some of the addicts are already taking the maximum doses of medication and if their symptoms worsen with time, there may be little that can be done for them.

All of the addicts who have been treated have been released from hospital, Dr Langston said, but "we have no way of predicting what their condition will be like five years from now."

There are probably several hundred addicts, Dr Langston estimates who have taken one or two doses of MPTP-contaminated drugs but have not developed symptoms severe enough for them to seek medical help.

Addicts with a few exposures to MPTP probably have sub-clinical damage in the brain nuclei that MPTP attack. "These nuclei are thought to be very sensitive to age. So if they (the addicts) start off with half the normal number, because of exposure to MPTP, and lose a lot of cells in the normal aging process, they may start showing up in neurologists' offices in five to 10 years with strange symptoms," Dr Langston said.

One sure way for an addict to tell if he has MPTP-contaminated drugs, Dr Langston said, is that "this stuff burns when you inject it, which is different from any heroin that anybody has ever reported.

"There is reason to think that some of the drugs from this (illicit) lab (in San Francisco) may have gone to Texas," he added.

There is also a possibility that other basement chemists, trying to make MPPP, have wound up with a compound contaminated with MPTP. Donald Calne, a professor of neurology at the University of British Columbia, told the San Diego meeting that a case of MPTP-associated parkinsonism had been treated in the summer of 1981, in Vancouver, BC.

The implication is, Dr Langston said, that other basement chemists have fouled up in the past, and will foul up in the future, while trying to produce MPPP.

Briefly...

Illegible 'scripts'

CHICAGO — Prescriptions can be hazardous to health — if a doctor has sloppy handwriting. A survey by *American Druggist* magazine says more than half the pharmacists queried reported they had made errors dispensing medication because of the physicians' bad handwriting. On average, such mistakes happen 3.4 times in the careers of those pharmacists who responded. They're urging medical schools to emphasize penmanship.

Mothers keep puffing

TORONTO — A pregnant woman is more likely to give up alcohol than cigarettes, says a survey sponsored by the US National Institute on Alcohol Abuse and Alcoholism and the US National Center for Health Statistics. The survey of 7,000 mothers found that despite heavy publicity about risks, many expectant mothers continue to smoke. But the Surgeon General's 1980 report estimated that up to one-third of pregnant women quit, while another third cut down, says an article in *Medical World News*.

Milk makes it

LONDON — Scotch and milk? That improbable combination could be a familiar drink in British pubs if the Milk Marketing Board is successful with its new campaign. Britain has a surplus of 200 million pints of milk, and the board wants to encourage the use of milk as a mixer in alcoholic drinks. One method it's considering is selling pre-mixed drinks at supermarkets.

A positive outcome of addicts' tragedies

Parkinsonism research advanced

WASHINGTON — 'Basement chemists' who have synthesized a contaminated, synthetie heroin have inadvertently led to a significant advance in the study of Parkinson's disease.

Scientists at the United States National Institute of Mental Health (NIMH) here have produced the equivalent of human Parkinson's disease in laboratory monkeys with the contaminated street drug which caused "the shaking palsy" in some young drug abusers (see page 1).

Irwin Kopin, MD, Richard Burns, MD, and Sanford Markey, MD, of the intramural research program at the NIMH told a seminar here that, "Like Parkinsonian patients, the monkeys show slow movements, tremor, rigidity, and bent-over posture. They respond dramatically to treatment with L-Dopa (levodopa), the chemical the brain uses to make neuro-transmitter dopamine."

The researchers had attempted, unsuccessfully to use this contaminated analogue of meperidine (Demerol) to induce parkinsonism in lower animals like guinea pigs, rats, and cats.

However, it was found that the parkinson-like effects of the neurotoxic agent could only be achieved in monkeys, whose brain metabolism and function closely resembles that of humans.

The primates, developed irreversible cell damage after several daily injections of the contaminated meperidine analogue. There was continued deterioration even when drug administration was terminated.

Burns, Kopin, Markey: induced syndrome in monkeys

Also, like their human counterparts, the parkinsonian monkeys have extensive destruction of cells in the *substantia nigra*, the dopamine-producing area of the brain.

The monkey studies also suggest that the contaminated meperidine is relatively selective, damaging permanently only a part of the dopamine system; Parkinson's disease produces enduring effects on other systems as well.

Dr Kopin: "It's possible that 10 or 15 years from now we will have an epidemic of people who are developing Parkinson's disease because they have been exposed to this drug. It's like a time bomb. It may develop years later. These are things we just don't know."

He continued: "Since dopamine levels decline with age, we don't know if people who have taken drugs like these will develop Parkinson's disease because they have superimposed drug damage on aging damage."

Anyone who may have taken the drug is asked to contact Dr Burns, NIMH, 9000 Rockville Pike, Bldg 10, Room 3S-231, Bethesda, Maryland, 20205.

Rhetoric replacing US commitment in anti-drug crusade: congressman

(from page 1)

He recalled that Mrs Reagan on more than one occasion visited the Daytop Village during the presidential campaign, "and came away with a new cause which she has championed passionately ever since."

However, Msgr O'Brien said, "the hope, which glowed so brightly when Nancy Reagan first declared her commitment to the problem, is now gone. It is obvious her husband is either of a different opinion about the drug crisis or he doesn't care enough about the hopes that have been raised because of her work."

Congressman Rangel, in a plenary address, said "the failure of the present administration to make good on its soaring anti-drug rhetoric is one of the colossal disappointments of this decade."

He cited the reduction of federal support for drug treatment and prevention programs, the slowness of the administration to put into effect its proclaimed enforcement initiative, and failure to provide adequate funds for agencies with missions in the drug field.

"The illicit US market in all drugs is believed to handle some $90 billion a year," Congressman Rangel said.

"On television and in public print, Mrs Reagan is effective in drawing attention to the problem, especially in middle-class, mid-America," he said. "It's good stuff.

"But does it replace a concrete, across-the-board, federal commitment to the nation's chronically underfunded treatment and prevention programs?" he asked.

Mr Pruss, speaking for the TCA, called upon the Reagan administration to support an amendment to the 1978 federal forfeiture law to provide for sharing of assets seized by federal agents among law enforcement and treatment.

Chronic marijuana users still drinking says study

By Mark Kearney

NEW YORK — Marijuana use has not replaced or excluded alcohol consumption among chronic marijuana users, says a Kansas physician.

Ronald Weller, MD, an assistant professor of psychiatry, Kansas University Medical Centre, Kansas City, says a seven-year follow-up of 97 chronic marijuana users showed 86% were currently using marijuana and 90% were currently drinking.

When marijuana use "increased dramatically" in the early 1970s many thought it would replace alcohol, he says. However, his study confirms that, among a certain population, most use both drugs.

"Use of one drug did not generally replace use of the other," Dr Weller says in a paper presented to the American Psychiatric Association annual meeting here. "For example, during periods of decreased marijuana use, only 11% reported an increase in alcohol use."

The first phase of the study examined 100 regular marijuana users in 1970 and 1971. The subjects were white, middle-class students, and had used marijuana at least 50 times in the six months preceding the study.

The subjects' mean age was 22 years. Mean age for first alcohol use was 15.4 years and 18.6 years for marijuana.

Dr Weller says the group was ideal to study because subjects had used both drugs, had smoked marijuana long enough to establish patterns of use, were in the peak of age for use, and thus were more likely to have it replace drinking.

The mean age of the 60 males and 37 females followed-up was 27.5 years, and they had used marijuana for an average of eight to nine years.

Most used marijuana and alcohol as social intoxicants and on most occasions used "socially equivalent amounts" of the drugs, Dr Weller says. About 20% drank daily compared to 23% who smoked marijuana daily, he says.

Although alcohol and marijuana are "pharmacologically distinct drugs, ingested differently, and different in physiological effects . . . use is similar in many respects among regular marijuana users," he adds.

Motivated opiate addicts recover with naltrexone, therapy blend

By Mark Kearney

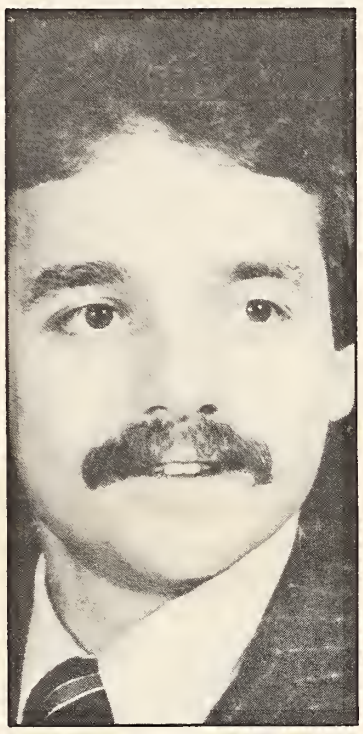
NEW YORK — The narcotic antagonist naltrexone is an effective treatment for one group of wealthy, suburban opiate addicts, claims a New Jersey doctor.

Mark Gold, MD, says 60.6% of 114 patients, all of whom had previously failed numerous detoxification attempts, successfully completed a six-month naltrexone treatment program. This completion rate is three to five times greater than reported for naltrexone by researchers working with other groups.

Naltrexone is a long-acting opiate antagonist which blocks the brain's opiate receptors. Last year Dr Gold reported its success in treating health professionals addicted to opiates (**The Journal**, Aug, 1982).

The drug is especially well-suited to treating a highly-motivated, "working addict who can use the time previously spent on drug procurement and drug abuse on career development," he told the American Psychiatric Association meeting here.

He says it's important, however, that highly-structured therapy and supportive programs accompany the naltrexone treatment for it to work. "Naltrexone given in a vacuum is just like any other drug (treatment)."



Gold: effective for some

Dr Gold, director of research at Fair Oaks Hospital in Summit, NJ, says naltrexone is non-addicting, non-euphoric, has no serious side effects, toxicity, or abuse potential, and reduces opiate craving.

In many cases, he says, recovering opiate abusers turn to alcohol as a substitute for the drugs. But Dr Gold believes drinking is better than opiate addiction because it's not against the law and is relatively more socially acceptable than drug abuse.

Patients with a serious drinking problem are directed to such programs as Alcoholics Anonymous to offset their newly-acquired habit, he adds.

In this study the patient's average age was 28.1 years, and 77% were males. Their average annual income was $41,400, and 45% entered the program because their jobs were at risk.

Patients took naltrexone for an average of 132 days. Follow-up interviews showed significantly more patients were employed and drug-free in the naltrexone group than those who had discontinued use after discharge, Dr Gold says.

He believes naltrexone should be taken for at least six months and preferably longer to help prevent relapse and give the patient time to adapt to a life without drugs.

Focus on fears, emotions can enhance psychotherapy for cocaine abusers

NEW YORK — Cocaine users may take the drug as a "substitute for love," says a New York City doctor.

Richard Resnick, MD, a researcher at the New York Medical College, department of psychiatry, says users are trying to cope with loneliness and despair, and to fill a "void of chronic boredom."

"What can help is long-term psychotherapy that allows them (the users) to express their feelings and fears in a caring, loving environment," Dr Resnick told the American Psychiatric Association meeting here.

Psychiatrists should tune into their own fears and faults to better understand their patients and provide love, concern, and respect for them, he says.

Dr Resnick adds that some users find cocaine enhances their expression of emotions, ideas, and feelings. Most of the 430 users interviewed by Dr Resnick and other medical college staff reported cocaine relaxes them, the others said it changed their regular sexual habits.

"Some individuals engage in group sex, homosexuality, or sadomasochistic sexuality only while high on cocaine. The anticipation of participating in these activities is a major motivation for some users to take the drug," Dr Resnick says.

The users report, however, that dysphoria and depression can follow the initial good feelings if cocaine isn't continued. Many, therefore, keep taking the drug to avoid those bad feelings, he adds.

Some users report the drug controls their life, and they need outside control to prevent their spending too much money on it. Users who spend $50,000 a year on cocaine are not unusual, he says.

Resnick

The problems associated with and causing excessive cocaine use are complex. Dr Resnick says long-term treatments are needed to ensure the users' emotional stability.

"They grope desperately for the meaning of life and take cocaine . . . to have a drug-induced feeling of well-being," he adds.

R_x safety advice sent to 36 million

WASHINGTON — The US Food and Drug Administration (FDA) will enclose a message concerning the proper use of prescription medication to the 36 million Social Security recipients this month.

The FDA is taking this action as a result of two FDA-sponsored surveys that suggest there is a low level of communication between patients and their doctors and pharmacists about prescription drugs.

"We hope our question-asking campaign will close the huge gap that exists between what patients say they are receiving and what health professionals say they are communicating about prescription drugs," says Paul G. Rogers, former Congressman and chairman of the National Council on Patient Information and Education.

Pondering conqueror's potable preferences

By Wayne Howell

Lately, there has been an increased interest in the drinking habits of historical and literary figures and how those habits might have affected the course of history or literature. Alexander the Great, for instance, has come under suspicion as a tippler who might have been greater had it not been for his love of the grape. The jury is still out on Alexander, however (**The Journal**, Feb, 1981, Jan, 1983). There are those who feel that the Greek was a definite *gamma*, and those who feel that he just liked to have a few with the boys now and then, after a hard day of city-sacking.

The situation is just as confusing in the case of Vittore Francesco Spritzi, the Genoese *condottieri* commander who dominated northern Italy from 1389 to 1425. Two recent books (J.R. White's *Spritzi in History*, and E.P. Black's *The Seige of Alba Revisited*) address the question of Spritzi's drinking habits and their effects upon the history of the Italian states in the middle ages.

Both writers agree that Spritzi's decision to lay seige to the Piedmont city of Alba was a disaster, and the failure of that seige had long-term consequences, not only for Spritzi (who died in it) but also for the Duke of Milan, the Dutchess of Bergamo, and the Duke of Mantua, not to mention the Pope, the King of Naples, and the Hohenstauffen Emperors. But they disagree as to the reason for the decision.

White argues that there was no strategic or tactical reason for beseiging Alba. Spritzi should have simply bypassed the stronghold and marched on Milan where he could have made short work of the disgruntled Swiss mercenaries in the pay of the Lombard League. According to White, Spritzi's decision to beseige Alba had its origins in Spritzi's well-known love of drink; he could just not resist taking the town of Alba and its many cellars of fine Nebbiolo wine.

Black dismisses this scenario as "speculation not in keeping with the facts." Spritzi failed, says Black, not because he was basically a drinker who could not pass up an unopened cask, but because he was basically stupid. According to Black, the manner of Spritzi's death (he died while cleaning out the barrel of one of his seige cannons with a lighted candle) confirms this. White acknowledges that Spritzi died in this manner but feels that, if anything, it strengthens the case, because this is the typical kind of misadventure associated with the abuse of beverage alcohol and a clouded state of consciousness.

Black is most convincing when he quotes the Venetian monk Fra Constipato — the most reliable chronicler of these turbulent times — to the effect that although Spritzi had an affection for the grape, white wine was his pleasure, not red. If, says Black, Spritzi wanted to beseige a Piedmont town to replenish his wine stores, then surely he would have beseiged the town of Gavi, famous for its golden Cortese wine, not Alba, where tannic red wine was all he could hope to plunder.

White considers this reasoning most specious; Spritzi's appetite for alcohol knew no limits, he says, pointing to the incident at the Duke of Verona's 1422 Christmas party as proof. Black counters by suggesting that the source of the Christmas party story (the Duke of Verona's daughter) is simply not credible, and counters with a quotation from Fra Constipato to the effect that not only was Spritzi a white wine drinker, he was a moderate one at that, mixing his wine with water, or water from mineral springs when he could get it. According to Constipato, a drink composed of equal parts white wine and mineral spring water garnished with a slice of lemon was known at the Venetian court as a '*vino bianco Spritzi*', or 'white wine spritzer.' Not only did Spritzi drink this beverage of moderation, he also eschewed the heavy, grease-laden meat dishes so popular at the time, preferring to dine on a simple quiche in a soul-satisfying environment of green, hanging plants. Following such a meal he would often mellow-out in a wooden tub to which hot water had been added. White dismisses this tale as a fantastic invention of Fra Constipato, in effect, saying "tell it to the daughter of the Duke of Verona." And so the matter rests.

What is certain is that Spritzi was cut down in his prime, the Visconti family established itself in Milan, the city on which Spritzi and his *condottieri* were marching, and Spritzi's name lives on only in obscure manuals of artillery-piece maintenance under "things not to do."

What Black and White will have to say about the PhD thesis of J.R. Gray which has just been published remains to be seen. Gray claims to have uncovered manuscripts in the archives of the University of Genoa showing that Spritzi attacked and looted Gavi before marching on Alba.

NEWS

RESEARCH UPDATE

Airborne smoke problem

Non-smoking airline flight attendants inhale the equivalent of one cigarette each on a flight across the Pacific says a recent study. Researchers at the San Francisco General Hospital Medical Centre tested six, non-smoking, female flight-attendants on flights from San Francisco to Tokyo and return, to see how much carbon monoxide and nicotine they absorbed. Donna Foliart, MD, Neal Benowitz, MD, and Charles Becker, MD, estimated the women, on average, were exposed to 0.12 mg to 0.25 mg of nicotine, because of passive exposure to cabin air contaminated with cigarette smoke. Carbon monoxide was not absorbed to any significant degree.

New England Journal of Medicine, May 5, 1983, v.308:1105.

Cigarettes and the fetus

A British doctor has completed a study showing a new pathogenic pathway for the negative effects of maternal cigarette smoking on fetal growth and development. Peter Buchan, MD, of St James University Hospital, Leeds, Eng, reported that blood was collected at birth from the umbilical vein of 40 infants, whose mothers had smoked more than 20 cigarettes a day during pregnancy, and a control group of 40 infants with non-smoking mothers. The study found maternal smoking resulted in changes in fetal blood viscosity similar to those which occur in non-pregnant adult smokers. This rise in blood viscosity "would be apt to reduce blood flow significantly," Dr Buchan said, and would cause fetal hypoxia (reduction of oxygen supply to body tissues) which would further stimulate an increase in blood viscosity. A vicious circle of decreasing blood flow and further hypoxia could result.

British Medical Journal, April 23, 1983, v.286:1315

Cocaine use and cerebrospinal fluid leak

Snorting cocaine apparently can cause the leaking of cerebrospinal fluid from the nose. A case was recently reported of a 34-year-old man who admitted sniffing cocaine seven times a year for the past 19 years. He reported to University College Hospital in London, Eng, with a six-day history of nasal discharge. E. H. Sawicka and A. Trosser said the man had cerebrospinal fluid rhinorrhea, a condition most commonly caused by trauma, in which cerebrospinal fluid is discharged through the nose. In the study it was noted that chronic abuse of cocaine can lead to chronic inflammatory changes and perforation of the wall separating the nasal passages and that similar chronic damage to other parts of the nose could "ultimately lead to a leak of cerebrospinal fluid."

British Medical Journal, May 7, 1983, v. 286:1476

Self-medication with alcohol

Researchers at the University of California, Los Angeles, say they have developed a model explaining the relationship between depression and alcohol over a one-year period. C. S. Aneshensel and G. J. Huba indicated that while alcohol may decrease levels of depression in the short-run, in the long-term alcohol use tends to heighten depression levels. This study, which is reported to be the first assessment of the long-term mood consequences of alcohol consumption, involved a representative sample of 742 adults residing in Los Angeles County. The researchers inferred from their results that a feeling of depression may be followed by an attempt to self-medicate by using alcohol but this fails after a while and heightens depression. "A potential mechanism for this effect is that the high levels of drinking will lead to social impairment, which causes failure and subsequent depression," the study said.

Journal of Abnormal Psychology, May, 1983, v.92:134-150

Attention deficit disorder

Pemoline, a central nervous system stimulant, may be useful in treating alcoholic patients who also have an attention deficit disorder, a recent case study indicates. Doctors at the psychiatry department of the New York Hospital-Cornell Medical Center reported on the case of a 35-year-old man with a long history of alcohol and heroin abuse who was also incapable of sustained concentration and showed antisocial personality behavior. But when treated with 37.5 mg of oral pemoline at first daily and later twice a day, the man was "less restless and distractible and had fewer emotional outbursts." He was released from an alcohol rehabilitation service on a maintenance dose of pemoline in conjunction with oral disulfiram and after 13 months was reported to be abstaining from alcohol. The researchers cautioned that experience with pemoline in the treatment of attention deficit disorder and substance abuse is "quite limited," and recommended the drug be prescribed only under research conditions until its safety can be further established.

American Journal of Psychiatry, May 1983, v.140:622-624

First drug experience

The first experience a person has with a drug can be related to their subsequent drug habit. This is the conclusion of a study conducted by C. A. Haertzen, T. R. Kocher, and K. Miyasato at the the US National Institute on Drug Abuse, research division, Addiction Research Center at Baltimore City Hospital, Baltimore, MD. The relationship between the reinforcing quality of the first drug experience and eventual habits for a variety of drugs was studied using 42 male drug abusers who were predominantly opiate addicts. In interviews, these subjects expressed how much they liked their first experience with a drug. Positive first experiences were linked with subsequent use of alcohol, barbiturates, minor tranquillizers, cocaine, stimulants, marijuana, glue or solvents, hallucinogens, opiates other than heroin, and especially heroin. The study noted that "the drug first used to get high is frequently the drug of addiction," and "the later habit and/or addiction for various drugs is predictable from the index of reinforcement (used by the researchers)."

Drug and Alcohol Dependence, April 1983, v.11:147-165

Cocaine helpline probes 'hidden' abuser profile

By Harvey McConnell

WASHINGTON — Dysfunction from cocaine use is much higher than has been estimated, says the director of the New York Medical College Cocaine Helpline.

The telephone helpline, which has received more than 2,000 calls since its inception in New York City in February, conducts extensive interviews with the anonymous callers.

The helpline was set up in response to many callers seeking confidential help, Arnold M. Washton, PhD, director of the division of drug abuse research and treatment, department of psychiatry, and associate professor of psychiatry at the New York Medical College told a science and press seminar at the United States Alcohol, Drug Abuse and Mental Health Administration.

Previous studies of the social, recreational use of cocaine "obscure the extent of dysfunction among cocaine abusers we are seeing currently, at least in New York," said Dr Washton.

Cocaine is no longer the province of the wealthy. It has spread to the middle- and working-classes, he said.

He added: "We have been struck by the fact that we found no differences between intranasal (sniffing, snorting), freebase (smoking), and intravenous users in terms of the dose or frequency of cocaine use or, even more surprisingly, the incidence, type or severity of reported consequences.

"Contrary to expectations, intranasal users reported no fewer, or less-severe consequences than freebase smokers or intravenous users. This challenges the popular belief that intranasal use guarantees freedom from the harmful effects of cocaine," Dr Washton said.

Thirty-minute interviews with the first 55 callers to the helpline found "most of our subjects began with occasional cocaine use and were rather surprised at how quickly and intensely their use escalated to compulsive patterns, particularly since they had previously believed that cocaine was non-addictive," he added.

The helpline provides callers with an anonymous way to consult about their problems and to obtain advice and referrals. Dr Washton said the sample was biased since all of the callers were problem users as self-defined by their calling the helpline.

Among the first 55 callers to the helpline 78% were male; the mean age was 33 years; 56% were White, 35% Black, and 9% Hispanic; 49% had incomes of more than $25,000 a year, and 53% would be classed as white-collar, professional, or business owners.

Primary route of administration was intranasal by 51%, freebase smoking by 22%, and intravenous by 27%.

Dr Washton: "We were rather astounded to find that average use was eight grams a week at a price of more than $100 a gram. Two people said they had spent more than $150,000 on cocaine in the year prior to calling."

Average use was six days a week, and 56% reported they used cocaine daily at their current level for the past two years.

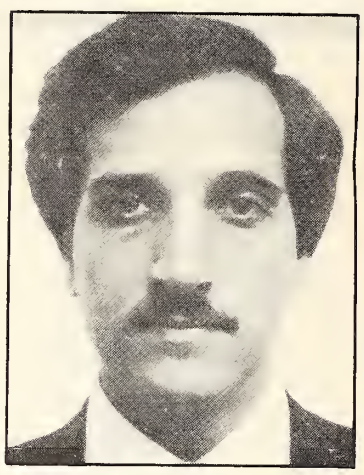
Of the sample, 93% felt they were psychologically addicted to cocaine and the majority wanted to stop "but realized they cannot do it without help."

Physical symptoms included nose bleeds, exhaustion, headaches, and seizures with a loss of consciousness. Psychological symptoms ranged from paranoia and panic attacks to violence against other people.

The subjects reported they were either late or absent often from work and were not able to focus on specific tasks, had impaired relationships with a mate, and were running into debt.

"Perhaps the most disturbing finding of all was that six of these 55 callers reported *grand mal* seizures with a loss of consciousness on at least several occasions," Dr Washton said.

One woman said she had had three seizures in one evening, and friends told her she had had severe convulsions, "But she said she went right back to smoking from the freebase pipe."



Washton: disturbing findings

The rate of violence was also surprising: many callers said cocaine use made them feel they wanted to hurt people and six reported injuring others while using cocaine.

Four of the callers had attempted suicide and 6% said they had been in automobile accidents following cocaine use.

Among the callers, 64% reported no other drug use while the remaining 36% said they used tranquillizers, marijuana, alcohol, or heroin to reduce the dysphoric crash following cocaine use.

While the callers reported desirable mind-altering effects of cocaine when they first started to use it, "these desirable effects diminished or disappeared entirely with continued, chronic use and were increasingly replaced by adverse effects," Dr Washton said.

He added: "The large volume of anonymous calls to our helpline suggests that a substantial portion of the cocaine abuse that currently exists is otherwise hidden from scientific or public analysis.

"There is clearly a need for expanded research, and treatment efforts to combat the current epidemic of cocaine abuse in the US and prevent it from escalating further."

Drunk convictions soar in Scotland

EDINBURGH — Scots may be hitting the bottle harder, says a report in *Doctor*.

Convictions for public drunkenness have nearly tripled and hospital administrations for alcoholism and alcoholic psychosis have risen by more than seven times in the past 30 years.

Current definition of FAS excludes children who lack classic physical symptoms

By Maureen Brosnahan

WINNIPEG — A new study suggests children born to women who drink heavily during pregnancy can suffer brain damage and other problems without the classic physical symptoms of fetal alcohol syndrome (FAS).

Victor Chernick, MD, professor of pediatrics, University of Manitoba, has been studying infants born to alcoholic mothers by monitoring their brain waves during sleep. He said that, in light of his findings, the definition of FAS needs to be re-evaluated.

"The current definition of FAS is totally inadequate. Only 34% of the babies we've studied have physical deformities."

He said only three infants in his study had the full-blown classic syndrome features such as thin upper lip, flat face, low-set ears, and small eyes. However, after comparing the brain-wave scans of infants born to mothers who were "frankly alcoholic" to those of mothers who did not drink during pregnancy, there was a marked difference.

"The results to date are rather devastating in a sense," he said, adding that many FAS children are underdeveloped and their head sizes are often two centimetres less in circumference than the head size of normal babies.

"That represents 10% less in brain matter," Dr Chernick said.

Dr Chernick has been studying FAS children by monitoring their brain waves during various stages of sleep with an EEG (electroencephalograph) since Jan, 1982. He is monitoring 100 babies in a long-term study funded by the Canadian federal health and welfare department which he hopes to continue for six years.

He said follow-up studies, which are now being done when children reach six weeks of age, show that the abnormalities found in the brain waves at birth persist, indicating they were not just symptoms of alcohol withdrawal. "They don't catch up by six weeks of age," he said.

"These are very preliminary results. We have a lot more work to do," he told a national conference on FAS here.

NEWS AND COMMENT

'Pride of people something to build on'

Archibald heads Bermuda probe

TORONTO — Growing concern about alcohol and drug abuse in Bermuda has led the government to appoint a one-man Royal Commission to examine the problems and recommend solutions.

H. David Archibald, who directed the founding of the Addiction Research Foundation of Ontario (ARF) here was invited to the post by the Premier and Governor of Bermuda. Mr Archibald, who is now president of the International Council on Alcohol and Addictions, told **The Journal** Bermuda is "most anxious and committed to try to do something very positive to reduce the impact of (alcohol and drug abuse) and to bring it into a reasonable proportion."

Bermuda is facing an increase in the use of cannabis, heroin, and cocaine, and an "apparently long-standing and sizable problem of alcoholism and alcohol problems," he explained.

"It is remarkable the similarity of problems seen in Bermuda and those in many other countries. The solution may not be the same, but certainly the kinds of problems are the same."

However, Mr Archibald added: "The government has serious concerns about the impact of drug and alcohol use on the economic processes which are particularly acute on an island which is not developed industrially and is largely dependent on tourism."

As commissioner he will meet with more than 80 institutions, organizations, groups, and individuals in Bermuda. He will study the needs and problems of the community and recommend improvements for existing treatment, education, prevention, and law enforcement. He will also consider the personal, social, and economic costs of illicit drugs and alcohol.

Mr Archibald anticipates that prevention strategies will be a key feature of the Commission's blueprint for action. The Royal Commission will also be a public education instrument and will provide information to the government and people of Bermuda.

Archibald: prevention the key

Mr Archibald, who was appointed commissioner on June 14, said he was "impressed by the tremendous pride of being Bermudian: White, Black, prisoner, or premier, the pride is there, and that is something to build on."

However, he cautions, "I have stressed that they should in no way expect to be able to import programs from Canada, the United States, the United Kingdom or any other country to solve the problem in Bermuda. The people in Bermuda will have to come to grips with the problem themselves and any assistance from outside will have to be adapted to their needs.

"My experience has indicated clearly that you can import some technique and some knowledge, but the actual program has to be adapted to the local culture."

GILBERT

'. . . we should spend nothing more on programs to help people to quit that are not research-based. . .'

Smoking control efforts

By Richard Gilbert

I gave the after-lunch speech at the annual meeting of the Ontario Inter-Agency Council on Smoking and Health in May. I was asked to "challenge the delegates to be more effective in their smoking control efforts." Here is the thrust of what I said.

There are four focuses of smoking control:

1. Preventing smoking in the first place.
2. Getting smokers to quit.
3. Getting smokers who cannot quit to smoke less.
4. Getting smokers to smoke in a way that does not harm or annoy other people.

Of the four, preventing smoking is by far the most important enterprise, in terms of lives extended and illnesses avoided, particularly because regular smokers usually cannot or do not quit. Prevention should receive the lion's share of available resources. Three aspects of preventing smoking can be stressed: attitude, availability, and awfulness.

The prevention of smoking is most usefully an exercise directed at children between nine and 17 years. Very few smokers begin as adults: most children who smoke regularly continue as adults. Prevention campaigns are usually directed toward getting children to believe that smoking is dangerous or addictive, or both. Most campaigns seem to be successful in encouraging these attitudes in the children, but unsuccessful in terms of their impact on children's smoking.

The most popular kinds of prevention campaigns may be less effective than they could be on account of the kind of attitude about the perils of smoking that they encourage. It strikes me that children are much less concerned about health and freedom than they are about not appearing stupid or unusual. Prevention campaigns might be more effective if they built on the horror that teens and pre-teens have of exposing themselves to ridicule.

Fear of ridicule

A recently described Australian prevention campaign would seem to have appealed to children's well-developed sense of the ridiculous. It was carried out by a group known as BUGA-UP (Billboard-Utilizing Graffitists Against Unsavoury Promotions). The campaign was directed against what the group regarded as unsavoury promotion of Marlboro cigarettes, the most popular brand in Australia. The campaign was a quest for Australia's "Marlboro Man." BUGA-UP recruited an emaciated victim of the cigarette habit who continued to smoke through his tracheostomy tube. Posters seeking the Marlboro Man were "refaced" with a picture of this particular smoker and the message that he would be the ideal candidate.

Although BUGA-UP's campaign made the points that smoking is dangerous and addictive, the predominant attitude conveyed seemed to be that smoking can make you look foolish. I know little about the effectiveness of the campaign, but nevertheless have a feeling that appeals to children's fear of ridicule could be exploited with great potency in prevention campaigns.

Even ridicule may not work, in which case physical methods of prevention should be given more emphasis than they are at present. Reducing availability and increasing the awfulness of cigarettes are two such methods.

Availability of cigarettes to children could be easily restricted in two ways. One would be to enforce the Minors' Protection Act in Ontario, and the equivalent legislation in other places. This Act states that "no person shall . . . sell . . . to a child under 18 years of age cigarettes, cigars or tobacco in any form." The other kind of restriction on availability consists of raising the price of cigarettes, which would have a stronger impact on children because, for the most part, they have less money.

There is little direct empirical support for the notion that restricting availability would prevent smoking in children — largely because very little work has been done in this area. We know that 80% of smoking kids buy their cigarettes in local stores, and it's a fair guess that less would be smoked if they were not available in this way. We know also that, generally speaking, consumption falls as cigarettes become more expensive in relation to disposable income, and there is little reason to suppose that children would be exempt from this general rule.

When cigarettes were stronger, the early pubescent ritual of furtively smoking the first cigarette was usually followed by vomiting and other unpleasant results. Today's tubes of aerated tobacco give the typical pre-teenage or teenage experimenter no such cause for revulsion. The trend to lighter cigarettes has removed a potentially important deterrent to progressing from the first cigarette to the full-blown habit. Indeed, there is evidence that teenage females find it easier to develop the smoking habit when very light cigarettes are available, and we know that during the period 1955 to 1975, while average tar and nicotine yields plunged, teenage girls were the only group in Canada who smoked more.

Futile business

Getting people to quit smoking is mostly a futile business. Among current therapies only aversive oversmoking and the use of nicotine-based aids (such as nicotine chewing gum) show promise. Each of these techniques brings its own health hazards, particularly oversmoking. For the rest, typically four out of five would-be quitters are back smoking within the year. This rate seems to be the norm, whatever technique is used. It is probably not very much higher than what might be called the "spontaneous quit rate," ie, the rate of quitting among smokers who receive no formal theapy. Indeed, I suggest we should spend nothing more on programs to help people to quit that are not research-based — except perhaps on programs involving nicotine aids.

Research-based quitting programs may do well to focus on some neglected and potentially promising areas:

1. Emphasizing the immediate health benefits of quitting rather than the long-term benefits: We know that there are measurable benefits to health even during the first day of quitting, and on each cigarette-free day thereafter. Quitters could be made aware of these benefits. Their resolve might be better fortified by such immediate gain rather than by knowledge that death will occur 25 rather than 20 years hence.

2. Focusing on relapse rather than on quitting: Most techniques show initial success and eventual failure, and yet most research has been on how to get people to quit rather than on how to keep them abstinent. We know almost as little about relapse as we know about how millions of smokers have quit successfully without any kind of professional help at all.

3. Recruiting family members: A few informal observations suggest to me that children can be potent allies in getting their parents to quit. Clearly the recruitment of such help should be done with parental consent.

4. Capitalizing on the cost of smoking: Few smokers seem aware of the cumulative cost of their habit, which in Canada now averages more than $750 a year per smoker. This amount could enhance most people's wardrobes mightily, providing a daily reminder of the value of quitting.

Smoking less

Other things being equal, smokers do themselves less harm if they smoke fewer cigarettes, or if they smoke lighter cigarettes or if they smoke less intensively — ie, take fewer puffs per cigarette or inhale less. Smokers who cannot quit can improve their health and their longevity by switching to weaker cigarettes, provided they smoke the same number or fewer, with the same or less intensity. This appears not to happen. The trend to weaker cigarettes has been associated with increases in average per capita consumption and, in the case of some individuals, with more intense and frequent inhalation.

Nevertheless, it may be true to say that the promotion and marketing of low-yield cigarettes has improved the health of smokers. Overall, however, the health of the community may have been damaged by the trend to weaker cigarettes because it has made it easier for teenagers to take up the habit.

Two major trends in smoking behavior in North America in the last two decades have resulted in a reduction by about one-quarter in the proportion of the adult population that smokes, and an increase by about one-quarter in overall per capita cigarette consumption, with the result that each smoker smokes an average of 60% more cigarettes than in 1963. A third trend is more evident — the retreat from smoking all these cigarettes in public. Although many more cigarettes are being smoked, the evidence of this is becoming less apparent to the casual visitor, especially one who stays away from bars, restaurants, and certain places of entertainment. The fight to liberate users of public places from other people's cigarette smoke has been largely won.

Public smoking

I wrote the 1976 version of the Addiction Research Foundation's Fact Sheet on Tobacco, and incurred the wrath of non-smokers' rights activists by noting that "there is no evidence" that second-hand smoke is a hazard to the health of healthy adults. For the 1978 revision I changed the phrase to "there is only indirect evidence." This phrase was qualified by the author of the latest (Jan, 1981) edition, who noted a research finding that "non-smoking spouses of smokers have increased risk of lung cancer." Three studies of this possible phenomenon were published in 1981. Two showed an effect. The third, which was the most sound methodologically, showed no effect: it consisted of a 12-year follow-up of 176,730 non-smoking women, stratified according to their husbands' smoking habits.

Although in 1983 the clinical and experimental literature provides more cause for concern about the health hazards of second-hand smoke, leading the Ontario Medical Association to issue a statement in April (**The Journal**, May) that appears to confirm the existence of long-term health effects in healthy adults, I would still use my 1978 phrase if I were revising the Tobacco Fact Sheet because it still provides the best description of the balance of the evidence. I would add that it is still very much better to emphasize offensiveness when justifying legislation to limit public smoking, or moves to enhance enforcement of such legislation.

Whatever the risk to health from inhaling someone else's smoke, it is certainly very much lower than the risk incurred in inhaling your own smoke. Furthermore, in emphasizing the health hazards of passive smoking, there is risk of distracting attention from or trivializing the indisputable hazards associated with active smoking, not to mention the other hazards — communicable diseases, for example —against which it is necessary to enact public health legislation. Public annoyance is a wholly sufficient and readily understandable reason for legislating controls over public smoking.

NEWS

Med students' cocaine use handled 'silently' by schools

By Harvey McConnell

SAN FRANCISCO — Large numbers of medical students in the United States try to control stress with cocaine and will enter practice already impaired by drugs and alcohol.

The medical establishment must be forced to grapple with the issue of drug use and abuse by medical students, warns David Smith, MD, who conducts a number of programs for impaired doctors and nurses.

Dr Smith, medical director of the Haight-Ashbury Free Medical Clinic and assistant professor of toxicology at the University of California Medical Center at San Francisco, (UCSF), said it is common medical knowledge that a disproportionate number of anesthetists and nurses who work in high-stress positions, such as intensive care units, are drug abusers.

"But what has become even more alarming is the recreational use and abuse of cocaine, which has absolutely nothing to do with the workplace, by medical students," Dr Smith told **The Journal**.

"There is an increasing use of cocaine in medical schools across the country and it is part of the social, recreational acceptance of cocaine that has plagued us for so many years."

Medical students use cocaine both as a recreational drug, and, even more often, as a way to cope with the stress of medical school. The increase in drug use in the US in the last 20 years has contributed to the problem.

Dr Smith explained: "Medical students don't have the same repulsion to the drug culture as do the older doctors and older nurses, who will have nothing to do with it.

"While the older doctors and nurses will divert legitimate drugs from the workplace, the medical students . . . will experiment with drug-culture drugs."

This experimentation extends to young, qualified doctors as well, but they will mix street drugs with legitimate prescription drugs.

Dr Smith said one young anesthetist was found recently to be using cocaine intravenously. "But to come down, instead of using heroin, as the drug culture does, he stepped back into the medical mainstream and diverted Demerol (meperidine)."

He added: "All of this is very heavy, but nobody wants to talk about it. It is a growing problem which people in medicine are afraid to tackle because they perceive it will give medicine a bad name.

"There is a conspiracy of silence. The 'search and destroy' mentality: if you catch a student who is using drugs kick him out and keep quiet." (See below.)

Dr Smith said that medical schools, as a general rule, have not taken addictive diseases in patient populations seriously enough, nor have they taken addictive disease in the medical student body and the medical profession seriously.

Dr Smith said that in one medical school a young student became involved with drugs, there was a successful intervention, he took time off to recover, entered Alcoholics Anonymous (AA), returned to school, and graduated. "And everybody in the student body knew he was a member of AA."

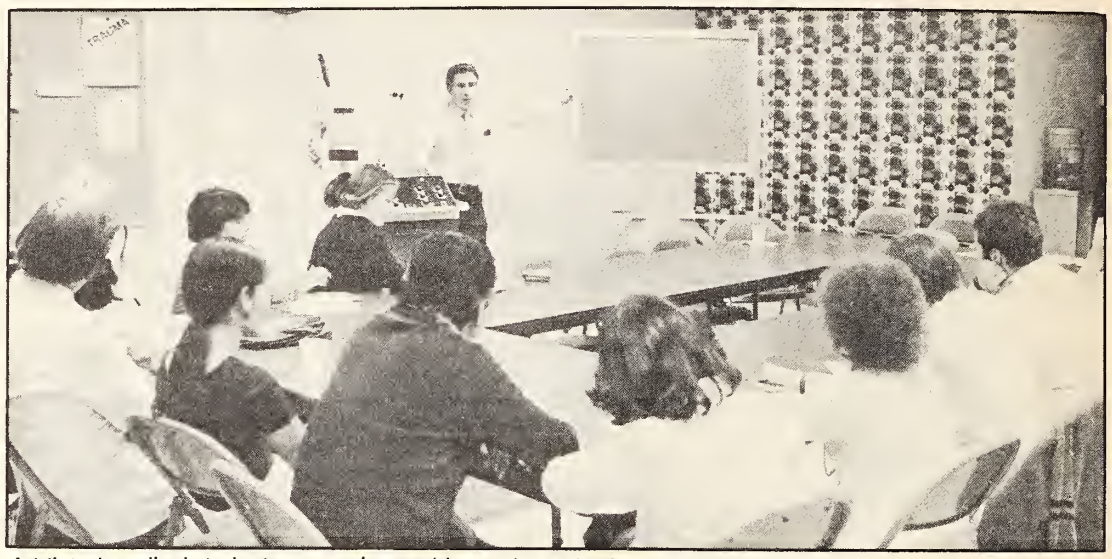
On the other hand, he said, at the UCSF, a second-year student died this spring from a cocaine overdose.

But the situation in most medical schools is that students with drug problems are afraid to talk about them. If they manage to kick their habits, and are recovering, they are afraid to talk about it because it might be used against them.

The first step in trying to solve the problem is to get medical school administrators to admit that their students use and abuse drugs. Medical students must learn addiction is a disease to which they are not immune and that addiction is a treatable disease.

He said that if the medical schools did tackle the problem, and taught the students the facts of life about addiction, within a decade, instead of a lot of impaired doctors in practice, the US would have an army of doctors who knew how to cope with drug use and abuse among their patients.

"But unless something is done to reverse the current situation then the number of young impaired doctors in the US is just going to increase year by year," Dr Smith predicts.



Addicted medical students: a growing problem — but nobody wants to talk about it

Faculty in quandary about addicted students

By Mark Kearney

NEW YORK — What responsibility do medical school faculty members have to the impaired medical student?

A student with an alcohol or drug abuse problem may approach a faculty member in confidence. The professor must then decide between responsibility to the individual and to the school and society which may ultimately be affected by the impairment.

There is no simple answer, but it's a problem that's receiving increasing attention at medical schools, says a Tennessee psychologist.

Danny Wedding, PhD, assistant professor of medical psychology at East Tennessee State College, Johnson City, Tenn, says medical students are not the only students with drug and alcohol problems. However, he's more concerned about medical students abusing drugs because of their future professional responsibilities.

"If a student is abusing drugs as a fourth-year student, then what will he be abusing in his fourth year of residency or his fourth year of medical practice?" Dr Wedding asked at a workshop here of the American Psychiatric Association (APA) meeting.

Abusing drugs or alcohol as a student is often a precursor to becoming an impaired physician if nothing is done about the problem, he says (The Journal, June). The students' ready access to a variety of drugs can also encourage abuse.

The student drug users, however, are often reluctant to approach someone in the medical school department for fear of damaging their career. They often see faculty members as having too much influence on their future to feel comfortable discussing their problem with them, Dr Wedding says.

Those who do admit their problem create a dilemma for the faculty member involved, he says.

Dr Wedding says his university tries to work closely with community groups who can assist impaired medical students and remove some of the responsibility from the professors caught in the bind between students and the school.

MDs can overcome addictive behavior

By John Ingalsbe

TORONTO — Nearly three-quarters of a group of physicians treated for substance abuse at the Donwood Institute here reported being mainly or totally abstinent in the 10 months following treatment, an Addiction Research Foundation (ARF) substudy says.

The study, by Alan C. Ogborne, PhD, and John F.C. McLachlan, PhD, found that 71% of a sample of 31 substance-abusing doctors were either mainly or totally abstinent and working as physicians in the 10-month follow-up period.

Dr Ogborne, a scientist with the ARF's London Research Centre, told **The Journal** the findings were encouraging but said the study was uncontrolled and cannot be taken as a definitive evaluation of the Donwood program.

Dr McLachlan, director of psychology at the Peel Memorial Hospital, in Brampton, Ont, said: "The study shows that physicians can overcome fairly long-standing reliance on chemicals and become reinvolved with work."

The study found that protective drugs played an important role in the doctors' dealing with drug abuse. Such drugs, Antabuse (disulfiram) and Temposil (calcium carbimide), were used on 54% of all alcohol-free days reported by the sample.

All of the subjects described their mental condition as "good," or "fair," but 61% admitted experiencing one or more types of psychological problems, such as nervous tension, depression, loneliness, or sleeplessness.

All but one of the physicians described the treatment program as either "moderately" or "very" helpful, and 84% of the sample indicated they would return for further help should the need arise.

The original target sample included 38 physicians, one of them female. (When interviews were conducted, two could not be located and five refused to participate or failed to keep appointments.) The average age was 44 years.

Fifteen of the original sample had alcohol problems only, another 15 had problems with alcohol and drugs, and the remaining eight had problems with drugs only (mainly narcotics and tranquillizers). Those with drug problems averaged seven years of abuse while those with alcohol problems reported more than 10 years of abuse.

Seventeen of the sample had been charged with impaired driving at least once and had had previous treatment for substance abuse. Twelve had some degree of liver enlargement. Five had made at least one suicide attempt.

In the three months prior to the interview all but one subject was working as a physician, 24 reported no use of alcohol or psychoactive drugs for at least five days prior, while nine reported no drug use during the previous three months. Five subjects who had remained completely abstinent during the 10 months following treatment later reverted to using some alcohol or drugs.

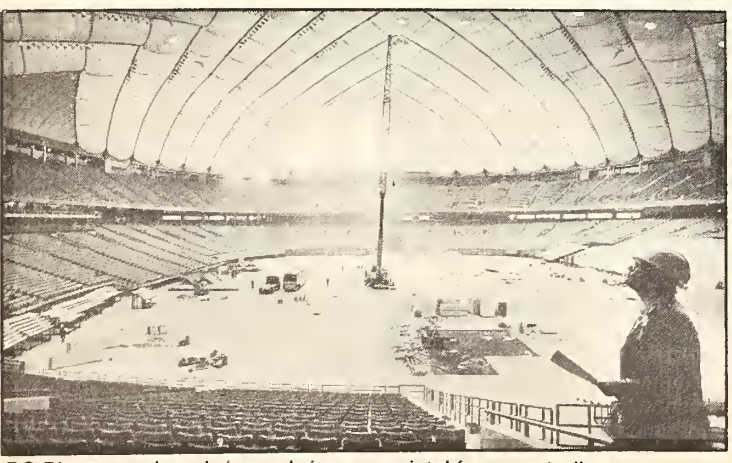
The study urges that controlled studies be carried out to resolve the question of whether the same results would be obtained if subjects were only encouraged to use protective drugs after treatment.

Stadium bows to pressure

Doctors seek veto on tobacco ads

KELOWNA, BC — BC Place, British Columbia's new, covered stadium, has given the province's doctors a commitment that consumer goods other than tobacco will be given priority in advertising within the stadium.

This commitment to Fred Bass, MD, chairman of the provincial doctors' tobacco and illness committee, resulted from a strong campaign by the physicians to keep tobacco advertising out of the Vancouver stadium.



BC Place: smoke ads 'grossly inappropriate' for new stadium

In fact, at the annual meeting here of the British Columbia Medical Association (BCMA), doctors voted to ask BC Place, the Vancouver Lions football team, and the Vancouver Whitecaps soccer club (both of whom will play in the stadium) to refuse all forms of advertising and promotion of tobacco and alcoholic beverages.

"It is grossly inappropriate to promote tobacco to teens," said Dr Bass.

He said that the opening of the stadium was an appropriate time for the type of resolution passed at the meeting.

The BCMA also supported a move to cooperate with Mothers Against Drunk Drivers (MADD), and to support the principle of stiffening the drinking-driving sentences.

Traditional alcohol therapy approaches need second look

Treatment intensity 'irrelevant' to success rate

By Mark Kearney

NEW YORK — Increasing the intensity of outpatient treatment for some alcoholics doesn't necessarily improve the success rate, says a Kansas psychologist.

Barbara Powell, PhD, of the Kansas City Veterans Administration Hospital, says outpatients who received 12 hours of multi-therapy each month for a year didn't differ significantly from those who were only followed up with a cursory check each month.

"The extent of treatment is irrelevant," she told the American Psychiatric Association annual meeting here. Clients who received multi-therapy such as counselling, group therapy, and vigorous casework were only slightly better at reducing their drinking.

The study's findings suggest traditional approaches to outpatient treatment are "not particularly effective" and new approaches are needed, Dr Powell says.

Therapists have to tailor the treatment to the patient and not vice-versa because "we're not the experts," she says. The traditional approach could be time-consuming and cost-inefficient, she adds.

Dr Powell and her associates studied 174 males who were hospitalized for alcoholism and followed up 78% of them a year later. She emphasizes this wasn't "a skid-row population" and 50% had never been hospitalized for alcoholism before.

The men were divided into the low, occupationally-functioning group (LOF) who were employed two months or less in the previous year and the high, occupationally-functioning group (HOF) who had 10 months or more employment in the preceding year. They were then randomly assigned into three groups: the control group; another group receiving medication only; and the multi-therapy group.

The control group received no medication or counselling but were simply asked once a month whether they were drinking or not. The medication group was given Antabuse (disulfiram) and/or Librium (chlordiazepoxide hydrochloride) without any counselling or therapy. The multi-therapy included individual counselling, group or family therapy if needed, medication, Alcoholics Anonymous, and vigorous casework intervention.

Dr Powell says she expected the HOF group to profit more from the multi-therapy than the LOF group but that result "did not emerge."

The LOF group continued to manifest more psychopathology and greater social impairment than the HOF group after a year regardless of the treatment received, she says.

"The treatment condition to which patients were originally assigned did not differentially influence the one-year outcomes of the HOF and LOF groups," Dr Powell adds.

The percentage of men who were still drinking or who had alcohol interfere with their work was about the same for each of the three therapy groups, she says.

Aging characteristics may impede diagnosis of substance abusers

By Mark Kearney

NEW YORK — Substance abuse among the elderly may be underdiagnosed because the symptoms differ little from what often accompanies old age, says an Oregon psychiatrist.

Roland Atkinson, MD, chief of psychiatry at Portland's Veterans Administration Medical Center, says symptoms such as memory loss, confusion, diarrhea, and accident proneness are common among elderly substance abusers and abstainers alike.

Physicians must realize the average older substance abuser is often middle-class and doesn't fit the public stereotype of the solitary, poor drinker, he says. Doctors must also be meticulous when obtaining histories of alcohol, medication, and other drug use.

Unexpected response to prescribed medication may often be a clue to a patient's undisclosed alcohol abuse, Dr Atkinson says. Elderly substance abusers may strongly deny their habit or hide it from a physician with the help of their family.

Social factors can also contribute to underdiagnosis, he said at the American Psychiatric Association (APA) annual meeting here.

"Younger people are often first identified as abusers by others," Dr Atkinson says. "But older people, retired and living alone, may not have sufficient contact with anyone (who could) discover and bring their difficulties to the attention of a treatment agency or physician."

Atkinson

Zimberg

Alcohol and drug abuse problems generally decline with age but up to 25% of men in their 60s are heavy drinkers, constituting "a health problem of moderate proportion," Dr Atkinson says.

Alcohol isn't the only problem. Studies show the oldest 10% of the population used 25% of prescription drugs in the United States. The elderly also are more likely to misuse over-the-counter drugs, especially ASA (acetylsalicylic acid) and laxatives.

As many as 30% of people beyond 60 years use laxatives daily while 10% to 20% report daily ASA use. About 85% consume coffee or tea daily with 11% drinking more than six cups of coffee daily.

Far less is known about use of illicit "street drugs" by the elderly, Dr Atkinson says, but there are reports of wealthy senior citizens using cocaine.

Sheldon Zimberg, MD, agrees substance abuse among the elderly is underdiagnosed, but, if discovered, a variety of treatments should be available.

Elderly alcohol abusers are not a homogeneous population, says Dr Zimberg, an assistant professor of psychiatry at Mt Sinai School of Medicine in New York City. Some have been drinking heavily for several years while others only started drinking late in life to cope with stresses of old age, he told the APA meeting.

Dr Zimberg says poor, elderly alcoholics usually respond better to a treatment approach that is directed toward everyday problems associated with old age rather than to alcoholism itself.

Wealthier alcoholics tend to have more financial and social support and, thus, often benefit from an approach that focuses directly on the drinking problem, he adds.

Elderly: tailor treatment to lifestyle

BC Natives lobbying for 'off-reserve' funds

By Eleanor LeBourdais

VANCOUVER — Twenty-two Indian Friendship Centres across British Columbia are lobbying the federal and provincial government to provide money offered under the National Native Alcohol and Drug Abuse Program.

The centres provide services to status, and non-status Indians, Metis and Inuit.

In April, 1982, the federal ministry of health and welfare announced grants of $154 million for alcohol and drug programs on Indian reserves (**The Journal,** Mar, 1982). The ministry also pledged to work with the provincial governments to provide similar programs for native Indians not living on reserves.

Rusty Wilson, executive director of the Mission Indian Friendship Centre here, says the lower mainland of British Columbia constitutes the largest Indian 'reserve' in Canada, but nothing is being done for the estimated 35,000 Indians in the area, who are faced with alcohol and drug-abuse problems.

Mr Wilson says some provinces have taken up the federal government's offer, but BC has made no move as yet to help off-reserve Indians.

In a position paper, the Friendship Centres suggest the provincial and federal government should provide off-reserve Indians with equal access to program dollars for alcohol and drug abuse, with treatment programs conducted through the Friendship Centres.

The group entered into discussions with federal government representatives in Ottawa in June.

TC academic agenda enhances clinical progress

'Miniversity' leads to gains in self-esteem

By Charles-Gene McDaniel

CHICAGO — Researchers at New York City's Daytop Village say educational activities enhance the treatment process in therapeutic communities (TCs).

Daytop researchers in 1979 inaugurated a so-called "miniversity" to provide intellectual growth and development to enhance the TCs' learning environment for emotional growth and development.

Vincent Biase, PhD, a clinical psychologist who heads Daytop's research and development, told the 7th World Conference of Therapeutic Communities here that, by every standard, those who enrolled in the miniversity did better than matched controls who participated in the usual drug therapeutic program.

The initial group of 122 included 42 control subjects and 80 students who took courses offered by senior professors from Brooklyn College. The group included males and females, members of all major ethnic groups, and ranged in age from 19 years to 44 years. Some had been out of school for as long as 10 years.

Dr Biase reported that 89% of those who enrolled in the courses completed them with an overall grade point average of 2.78 on a 4.0 point scale. These were regular college-level courses such as sociology and were not specifically designed for the centre.

The participants, he said, made an "extremely high gain" in self-esteem, as compared with controls. The experience gave participants a "sense of self-ability to learn" and provided them with real-life experience in a supportive environment so it was easier for them to overcome their frustrations when they had trouble learning.

At six-month follow-up, 66% of the miniversity students were enrolled for further education or training, and 76% were employed, compared with 33% and 50%, respectively, of the controls. Dr Biase said a study is now under way to look at how well the student group has fared two to three years after the year at Daytop.

The academic program involves the clients for three semesters after an initial settling-in period of about three months.

Clinical progress of the participants was enhanced also, Dr Biase said.

Among other auxiliary benefits, he reported an increased participation by Daytop residents in high school equivalency programs, a development Dr Biase attributed to the changed environment at the facility.

In another report, Sherry Holland, a psychologist and director of research at Gateway Foundation in Chicago, summarized her evaluation of studies of effectiveness of TC programs in general:

Biase: auxiliary benefits

- A 25% to 40% reduction in drug use by early dropouts from the TC program, and 85% to 90% reduction by graduates of TCs.
- A decline in criminal behavior ranging to 98% among program graduates from no change for early dropouts.
- An increase in the amount of time employed before and after treatment ranging from as high as 150% among graduates to 30% to 45% among dropouts.

In composite, she said, 20% to 30% of early dropouts and 85% of TC graduates were classified as complete successes as measured by their being drug-free, not involved in crime, and being employed.

She said future research should go beyond assessing whether a program works and should look at what works for clients. There is a general need for a more careful look at why dramatic changes occur in TC clients, she said.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Treatment 'sentence' aids convicted DWI repeaters

It was with keen interest that we read the article explaining the efforts to combat the impaired driving problem in Ontario — Drinking Drivers Get Halfway House Rehabilitation (**The Journal**, May). We congratulate the Ministry of Correctional Services and Mimico Correctional Centre for their leadership in allowing this type of programming to develop.

We would like to share with you some of the findings we have gained since the Impaired Driver Treatment Program (IDTP) was set up in Saskatchewan and became operational in Jan, 1980.

The IDTP provides a treatment option for those convicted of a second or subsequent impaired driving offence and who are under sentence of imprisonment. There are three inter-related components of the IDTP program: assessment and referral, treatment, and follow-up.

Preliminary screening, referrals, and pre-sentence reports are prepared to advise the courts as to the suitability of an offender for treatment. For those amenable to treatment, a sentence is imposed by the courts with a recommendation that the offender be transferred to the St Louis Rehabilitation Centre, St Louis, Sask.

The treatment component of the IDTP is provided at the St Louis Centre. This 30-bed facility provides an intensive 14-day program aimed at assisting and contributing to the on-going recovery from problems related to alcohol and/or other drugs.

The centre is designated as a correctional facility but is operated so as to provide a treatment environment. Clients are required to indicate a willingness to undertake treatment before they are accepted and, once they arrive, they are expected to participate fully in the program.

Up to 15 clients are admitted each Friday. The two-week, in-patient, treatment program is probably the shortest in Canada. It is designed simply as a foundation or starting point for recovery. The treatment goal is to contribute to the physical, psychological, social, and spiritual health of people with alcohol-related disabilities.

Offenders sentenced to St Louis have a six-month probation order attached to their sentence requiring them to report to the Alcoholism Commission to work out an on-going treatment plan. This will usually involve spouse, family, and after-care services such as AA (Alcoholics Anonymous), churches, and health care professionals. A follow-up report is made after six months, to complete the treatment contract. Recovery plans and services may follow for as long as needed with formal evaluation at one and two year intervals.

Follow-up services are provided by the Saskatchewan Alcoholism Commission to clients and their families for a period of six months following discharge from St Louis during which all clients are on probation or parole.

The program has been under way for three years. Interesting and valuable data emerged in the client profile produced from the recent interim report. We are most encouraged by the present indicators revealed in the report. The profile indicates that among drinkers, both frequency and volume of alcohol consumed was lower at follow-up than prior to treatment. The percentage of daily or weekly drinkers dropped by half to 39.4% of all clients at follow-up from 82.8% prior to treatment. During the six-month follow-up period, 20.9% of all clients reported drinking to excess.

A further evaluative study is being conducted with Dr Paul Whitehead as the principal investigator.

We thought **The Journal** and its readers would be interested to know of our Impaired Driver Treatment Program in Saskatchewan.

Angus R. Campbell
Chairman
St Louis Board of Governors
St Louis Alcoholism Rehabilitation Centre
St Louis, Saskatchewan

Acupuncture detox clinic now assists 400 a week

We appreciated your recent article on our acupuncture detoxification service (**The Journal**, May). The information was excellent except for the attendance figures. At that time we saw 300 detoxification patients a week and now we see more than 400 per week. Our growth has been so encouraging that the city has asked us to submit a substantial budget increase.

Keep up your good work.

Michael O. Smith, MD
Lincoln Medical and Mental Health Center
Substance Abuse Division
Bronx, New York

'Greatest war ever'

What a pleasure it was to receive the April issue of **The Journal** with the article on Lions Clubs International's world-wide, drug-awareness program. Our best wishes go to H. David Archibald, whom we were very pleased to have with us at our International Drug Symposium. He made a great contribution.

I am very impressed by **The Journal** and the varied and detailed information that is given in the news and opinion columns, and also all of the other announcements and notices on other material.

Thanks again for the feature article and your continued dedication to one of the greatest wars that we have ever had on our hands.

Everett J. "Ebb" Grindstaff
President
The International Association of Lions Clubs
Oak Brook, Illinois

Helpful tool for people problems

I have had the privilege of subscribing to your fine publication for the last several years.

It has been very helpful in our efforts to inform our students, staff, and community on items concerning people problems and how to deal with them.

As a person involved in the people problem field for more than 20 years, I anxiously await the arrival of **The Journal** each month.

Bernard G. Hoffman
Assistant Superintendent
Neshaminy School District
Langhorne, Pennsylvania

StatsCan extols TJ health article

Congratulations on the very well-written article, Healthier lifestyles could cut future health bill (**The Journal**, May), which I, and others, found to be accurate, fair, representative, and interesting. Your article is one of the better pieces done on our *Perspectives on Health*.

You may also find our just-released *In Sickness and in Health: Health Statistics at a Glance*, interesting.

Douglas E. Angus
Chief, Research and Analysis Section
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Statistics Canada
Ottawa, Ontario

Letters to the Editor may be sent to: The Journal, 33 Russell St, Toronto, Canada M5S 2S1.

Rational approach to alcohol problems needed: Mayer

NIAAA will expand research focus in 83-84

By Harvey McConnell

HOUSTON — The title of the United States National Institute on Alcohol Abuse and Alcoholism (NIAAA) conveys messages that have to be re-examined.

William Mayer, MD, administrator of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), of which the NIAAA is a part, said the institute is charged with addressing what he sees as two different sets of problems: alcoholism and alcohol abuse.

He is convening round-table discussions with the NIAAA's national advisory council and staff because "we are going to have to come along and say what, at this moment, we consider to be alcoholism, and what we consider to be alcohol abuse."

The ADAMHA, under the administration of President Ronald Reagan, "has enjoyed a largess of government funds that is unmatched by any other research enterprise in health." President Reagan has proposed a $12.5 million increase to $45.8 million for the NIAAA in the 1984 fiscal year, said Dr Mayer.

The president has also proposed budget increases to the two other ADAMHA institutes: a $9.1 million increase to more than $56 million for the National Institute on Drug Abuse (NIDA), and a $13.8 million increase to $172.1 million for the National Institute of Mental Health (NIMH).

There is now broader support from federal legislators and upper echelons of public health service, and other agencies of government are "now coming to us and wanting to work collaboratively with us in various aspects of the problem," Dr Mayer told the annual conference of the US National Council on Alcoholism (NCA) here.

Congress and the administration are becoming aware it does not make sense to invest 18 or 19 times as much money in cancer research, or 12 or 13 times as much in heart disease and stroke research, as is being invested in the problems caused by alcohol, Dr Mayer said.

While the message is getting through in a rational and business-like way, this presents some important challenges which cannot be ignored, he added.

Dr Mayer: "Some of the challenges have to do with the fact we are still engaged, to a certain extent, in a Byzantine maneuvering for ascendancy, for the recognition of our own point of view as being the ultimate truth, for turf battles. And that has not served us well."

Those interested in alcoholism and alcohol-related problems "still bear a not-unearned reputation for being unable to get together, for being constantly at war with one another, with bickering, backstabbing, and so forth."

Arguments can continue, Dr Mayer said, "but we are going to have to be able to present a somewhat more-unified and rational view of what it is we do, and what problems we address, than we have been able to do in the past, or we're going to be in trouble.

"We are going to have to continue to fight the myths with facts, not just assertions."

He would like to see prevention methods for the disease of alcoholism, "but I'm much more sanguine about the possibilities of developing some preventive measures against what is — from a standpoint of lives lost and dollars lost — the bigger problem of alcohol abuse."

Such prevention programs have more in common with the efforts of the NIDA and the White House Drug Abuse Policy office, and with many of the activities of the NIMH.

"I don't think those same statements can be made about efforts to prevent the disease of alcoholism. I think that's quite a different subject," Dr Mayer said.

No national media campaign will have much impact on the incidence of the disease of alcoholism. The need is to consider measures of social control, measures that involve public education and information, and other things which have a much greater promise of affecting the abusive use of alcohol by youth and adults, he said.

In fact, research on preventing alcohol abuse among teenagers will be a major target of the NIAAA in the 1984 fiscal year, Dr Mayer said. He later told federal legislators at budget hearings by US House of Representatives and Senate committees in Washington, DC, that this will include a multi-site, cooperative project to develop and test improved alcohol education techniques for teenagers.

Another priority of the NIAAA will be further investigation of inherited, biochemical and physiological factors in susceptibility to alcoholism. Particularly important, he added, are studies of possible genetic markers.

Research will focus on the possibility of reversing *in utero* damage caused by alcohol, and further assessment will be made of the nature and degree of risk to the fetus of moderate maternal drinking during and prior to pregnancy.

Mayer: fight myths with facts

Scientists at the NIAAA will continue a cooperative project with the department of defense to refine a promising procedure developed at the institute for diagnosing alcoholism and alcohol-related liver disease.

Although there may be a relationship between alcohol abuse and drug abuse, and many treatment facilities deal successfully with polydrug abusers, Dr Mayer told the NCA he does not consider it reasonable now to marry alcohol and drug abuse in one organizational structure. Nor should a new institution be formed to deal with addiction or chemical dependence.

At the budget hearings, Dr Mayer said the NIDA will expand research on the acute effects of marijuana on cognitive and behavioral performance, including the amotivational syndrome.

As for drug abuse, "despite a welcome downward trend in the use of some drugs, including marijuana, cigarettes, and cocaine, American youth still have the highest level of drug abuse in any industrialized nation (**The Journal**, April).

"It is also vital to learn about the impact of chronic use of marijuana on the brain and immune and reproductive systems, and about its potential as a carcinogen."

More research will be done on cigarette smoking, including projects aimed at analyzing the behavioral characteristics of tobacco users, and at clarifying the role of nicotine in perpetuating cigarette smoking. Experimental products containing nicotine which might help people stop smoking will also be studied.

He told the NCA the time may come when alcohol and drug researchers join together; there are already many joint activities among the NIAAA, the NIDA, and the NIMH to try to prevent chemical dependency among young people.

However, Dr Mayer said, the structure at present best serves what needs to be done, and "I think they ought to be kept separate but together in one administration structure (the ADAMHA)."

Inmates admit drug use often precedes crime

By John Ingalsbe

WASHINGTON — Two surveys recently released by the United States department of justice give further evidence of a significant link between crime and the use of alcohol and illegal drugs.

About half of all inmates in US state prisons said they had been drinking just prior to committing their offences, says a Bureau of Justice Statistics (BJS) bulletin. Nearly one-third of all inmates had been drinking "very heavily" (consuming four or more ounces of ethanol) in a typical drinking session.

A second BJS bulletin says one-third of all inmates were under the influence of an illegal drug when they committed their crimes, and 60% of this group had been drinking as well — 40% "very heavily."

The data in both bulletins are based on interviews with 12,000 inmates in state prisons in 1979.

The alcohol survey was the first attempt to measure the drinking habits of inmates on a nationwide basis. The fact that one of four inmates drank very heavily on a daily — or almost daily — basis in the year before incarceration "indicates an alcohol problem of staggering size," says the bulletin. But it cautions against concluding that heavy drinking is the sole cause of many crimes.

While 30% of prisoners admitted drinking heavily — at least eight cans of beer, seven glasses of wine, or nine ounces of 80 proof liquor — just prior to committing a crime, this was a typical daily drinking level for many of them, the study says.

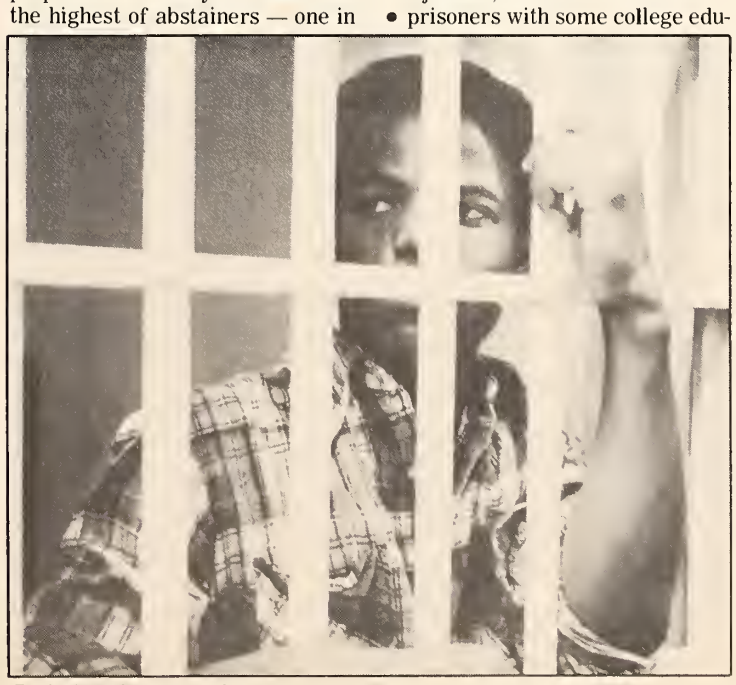
The survey shows that men in prison were three times more likely to consume an ounce of ethanol daily than men in the general population, while women in prison were five times more likely than women in general to consume that amount.

Inmates convicted of rape or assault were the most likely to have been drinking heavily just prior to the crime, while forgers and larcenists were the least likely. Two-fifths of all people convicted of rape, assault, or burglary drank heavily in the year prior to conviction.

Drug offenders had the lowest proportion of heavy drinkers and the highest of abstainers — one in four. Only one in 10 rapists did not drink alcohol in the year prior to conviction.

The study also revealed:

- Whites, Native Indians, and inmates between the ages of 18 and 25 years were most likely to drink heavily, while only one in five Black prisoners had been a heavy drinker;
- women inmates were only half as likely as men to drink heavily or drink daily;
- divorced people were most likely to drink heavily;
- those who had been employed were less likely to be abstainers and more likely to drink daily than the jobless, and
- prisoners with some college education were less likely to be heavy drinkers than those with less education.



Prelude to incarceration: 'alcohol problems of staggering size'

About 16% of drinking inmates had been enrolled at some time in an alcohol treatment program, the survey found. About 3% of all drinkers were enrolled in such programs at the time of the offence. More than two-thirds of those ever enrolled in a treatment program had been drinking heavily just before committing a crime, the survey says.

The survey on drug use among inmates found about half of those who said they were under the influence of an illegal drug at the time of their offence were under the influence of marijuana.

Further, three-quarters of the inmate population had used marijuana at some time — roughly the same proportion that had used any illegal drug.

One-fifth of inmates had never used drugs, one-fifth had used only marijuana, and another fifth had used six or more different illegal drugs. Heroin, cocaine, amphetamines, barbiturates, and hallucinogens (LSD and PCP) had each been used by one-third of the prisoners.

While the proportion of inmates using only marijuana was the same as for the general population, overall, inmates were about twice as likely as the public to have used illegal drugs.

While male prisoners were slightly more likely than female inmates to have used drugs, and to have used them recently, the differences were not great. About as many female as male inmates reported using cocaine, but heroin use, as well as recent heroin use, was more common among women prisoners.

Twice as likely to have used drugs

Half of all drug offences were committed by inmates under the influence of drugs, a fifth of them under the influence of heroin. About 25% of burglaries and 20% of robberies were committed under the influence of marijuana, while 12% of robberies and 10% of larcenies were committed under the influence of heroin. Cocaine did not play a significant role in the commission of any crimes, the study says.

Murderers, rapists, and disturbers of the peace were the least likely to have been using drugs other than alcohol at the time of their offence.

The survey found that slightly more than 25% of all inmates who had ever used drugs had been in a treatment program at some time. Higher treatment program enrolment rates were indicated among those who had used drugs recently and those who were under the influence of drugs when they broke the law. Heroin users were the most likely to have been in a program.

INTERNATIONAL

Poor nations suffer man-made disaster of smoking/cancer

By Thomas Land

GENEVA — The death toll of preventable cancer may rise from 400,000 now to more than one million annually around the world in the next decade.

This is largely as a result of the intensifying smoking epidemic in the developing countries, according to expert estimates placed before the United Nations (UN) World Health Assembly.

The assembly, the highest decision-making body of the UN's World Health Organization (WHO), called on the developing countries to attend to the challenge of man-made health disasters, such as the effects of smoking, with serious attention similar to that demanded by afflictions brought about by nature and a hostile environment.

Health Minister Chong Hon Nyan of Malaysia, president of the assembly, said smoking, alcoholism, and drug abuse as well as cancer "should be seen in the same light" as communicable diseases like malaria, cholera, and leprosy, and demanding urgent, corrective, public-health measures.

He added that many health problems once considered byproducts of affluence, and therefore the sole concern of the industrialized world, were now besetting the poorer, developing regions.

Experts are able to make long-term predictions on lung cancer mortality rates with some confidence because of the 25-year time lag between the development of smoking patterns and their effect on disease and health statistics. The spectacular, recent increase in cigarette consumption in The Third World is compared to that in the industrialized countries between the two world wars.

A WHO study estimates that up to 90% of lung cancer cases in the developed countries are caused by tobacco, chiefly in the form of manufactured cigarettes.

Efforts to find effective treatment for lung cancer have met with limited success. "The only remaining approach to lung cancer control," the study concludes, is "the implementation of programs aimed at primary prevention."

Another study quoted by the WHO agrees that the threat of cancer to an individual is more likely to come from cigarettes, alcohol, sunshine, and food — in effect from personal choices in life — than from industrial or environmental pollution.

North American statistics suggest that most forms of cancer can be prevented to the extent that lifestyles can be modified. Experts say the only evidence of a cancer epidemic in North America relates to lung cancer — caused primarily by cigarettes.

"In the developing countries, the smoking habit has spread like an epidemic," says a specialist spokesman for the WHO. "Although they have not yet had time to experience the grim increase in smoking-related mortality that has taken place in the industrialized countries, they must expect it unless they halt and reverse the increase in cigarette consumption. In many less-developed countries, the epidemic of smoking-related diseases is already of such magnitude as to rival even infectious diseases or malnutrition as a public health problem."

A WHO policy statement says the control of cigarette smoking in the developing countries "could do more to improve health and prolong life . . . than any other single action in the whole field of preventive medicine."

Thai opium control needs more assistance: NZ official

By Tony Garnier

WELLINGTON, NZ — Geoffrey Thompson, chairman of the New Zealand Misuse of Drugs Commission and a government undersecretary, has returned from a visit to Thailand a convinced advocate of crop substitution programs for the opium poppy.

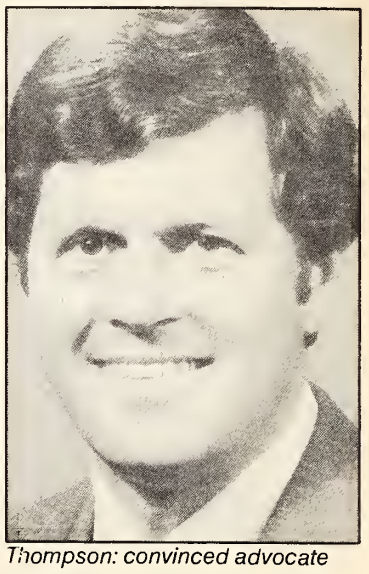
After the five-day visit, mainly in north Thailand, Mr Thompson said the villagers are clearly prepared to cooperate with any project that will give market returns as high as they get from the poppy — Cdn $34 per kilogram.

The undersecretary was in Thailand as a guest of the Narcotics Control Board there and visited some of the 57 villages in which the United Nations has been sponsoring crop substitution research for more than 10 years (**The Journal**, May.)

Only 14 villages have switched from opium to other cash crops, but United Nations workers are experimenting in 43 others, assessing likely replacement crops — kidney beans, potatoes, citrus fruits, peaches, and coffee.

Mr Thompson said the scheme could flag unless it receives more money, material, and advice.

He agreed crop substitution would eventually have to focus on Burma since much of the opium poppy grown in the Golden Triangle comes from the impenetrable Burmese highlands.



Thompson: convinced advocate

However, he said, at the moment efforts are being concentrated in Thailand, where the Thai government is anxious to rid the country of its heroin trade.

Mr Thompson suggested New Zealand and other western countries should work where they can, when they can, to assist in efforts to replace opium with other crops.

Oil boom affects Shetlanders' lifestyles

Drinking soars along with income

By John Ingalsbe

LONDON — Higher incomes, greater availability of alcohol, and other effects of industrialization related to oil industry development have resulted in a significant increase in alcohol consumption in the Shetland Islands off the north coast of Scotland, says a recent study.

It provides further evidence for the view that areas undergoing energy-related exploration and development face serious increases in addiction problems unless they plan for, and monitor, the situation (**The Journal**, Mar, 1983, Sept, Aug, 1981).

The study, published in the *British Journal of Addiction* (March)*, involved 263 men and women living in an industrial zone of the Shetlands and a comparison group of 270 inhabitants in a non-industrial area.

Structured interviews were conducted in 1975 and again in 1978, a period of unprecedented economic growth on the islands.

Alcohol consumption was found to have increased in both areas, but much more dramatically in the target area. There, consumption jumped by 24% while it rose by only 7% in the comparison area.

Since women in both groups showed about the same increase in consumption, the overall difference was because of differences in consumption by males.

The study found that among drinkers less than 30 years, total intake rose by 50% — five times higher than in older age groups. It singled out young males — 62% of heavy drinkers in the initial 1975 survey — as the most "at risk" for developing drinking problems.

Increased consumption in both Shetland groups resulted from an increase in the frequency of drinking, not an increase in the amount drunk on each occasion.

"The rise in consumption is thus insidious rather than obvious," the study says, "and should be more strongly related to long-term health consequences — cirrhosis, etc — than to sequelae of acute intoxication."

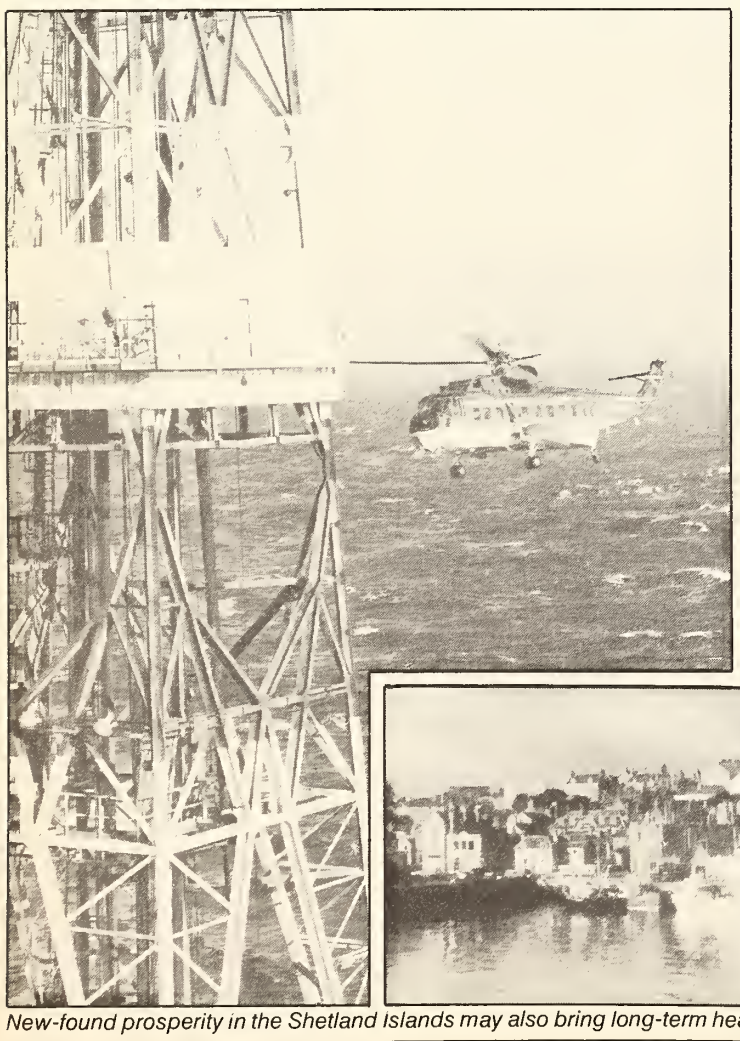
The study points out that between 1972 when oil was discovered in the North Sea off the Shetland Islands and 1978 when Europe's largest oil terminal was completed on the island the area's per capita income went from being one of the lowest to the highest in the United Kingdom.

During the study period, employment of Shetlanders in oil-related jobs increased eightfold; the proportion of people with incomes of more than £450 per month ($873 Cdn) rose to 37% in the target group and to 22% in the comparison group from 5%.

But after the discovery of oil, emigration decreased, housing shortages developed, schools became more crowded, traffic became more congested, and crime increased. The availability of alcohol increased in both study areas.

The study concludes government should take a much wider view of possible effects of industrial development on communities and, in addition to controlling industrial expansion through such methods as zoning laws, undertake monitoring of social and health related data to enable establishment of alcohol control policies.

**The Shetland Islands: Longitudinal Changes in Alcohol Consumption in a Changing Environment — Raul Caetano, MD, MPH; Richard M. Suzman, PhD; David H. Rosen, MD; and Deborah J. Voorhees-Rosen, RN.*



New-found prosperity in the Shetland Islands may also bring long-term heaith problems

Jimson weed use seen in Middle East MDs report

By Macabee Dean

TEL AVIV — Three Israeli physicians from the government-sponsored Sheba Medical Center have alerted their colleagues that Israeli youth might be using a type of hallucinogen new to the area.

In a recent issue of *Harefuah* (The Medicine), published by the Israel Medical Association, the doctors report the first case in Israel of the use of a common plant, *datura stramonium*, (jimson weed) to induce psychedelic experiences.

Two males aged 19 and 21 years, were hospitalized as a result of taking the hallucinogen which contains atropine, scopolamine, and hyoscyamine. Harefuah said it caused the subjects to "act strangely and babble aimlessly. Their skin was flushed and hot; their mouths were dry; their pupils were expanded and did not react to stimuli. Their pulse rate was 120; their bladders were swollen, and their intestines had stopped functioning."

The two recovered from the condition in about eight hours, but one "who acted violently, had had to be tied to his bed."

The physicians who sounded the warning noted that their patients' interest in natural hallucinogens was stimulated by reading the Hebrew translation of *The Teachings of Don Juan — A Yaqui Way of Knowledge*, by Carlos Castaneda.

Other Israeli youngsters could also be expected to try to concoct a potion from the plant, the doctors warned.

They also noted that although the drug is widely known in Asia and Africa, and sometimes mixed with tobacco, hashish, or other drugs, its use as a hallucinogen was believed to be unknown in the Middle East.

Superman at odds with Nick O'Teen

LONDON — Superman is moving to television to continue his battle with arch-enemy Nick O'Teen. The advertisements, sponsored by the Health Education Council here, dramatize the harm done by cigarettes, emphasize the anti-social aspects of smoking, and stress that children should "Never say yes to a cigarette."

Three-quarters of a million children have written to the council since the campaign began in Christmas, 1980 (The Journal, March, 1981).

Illicit exports flooding Western Europe, North America

Pakistan heroin 'outstrips' rivals in cost, quality

By Thomas Land

LONDON — A combination of international power politics and market forces has triggered an explosion of heroin production in the traditional opium poppy region of Pakistan's North West Frontier area, threatening North America and Western Europe with an unprecedented flood of illicit exports.

The recipient countries may respond by widening a project launched by West Germany for the establishment of an agricultural marketing infrastructure intended to enable the growers to switch to other crops.

The North West Frontier is part of the Golden Crescent of the Middle East (Pakistan, Afghanistan, and Iran), one of the world's two principal sources of heroin (**The Journal**, Apr, 1980, May, 1981). The Golden Triangle of Asia covers parts of Thailand, Burma, and Laos. (See The Back Page.)

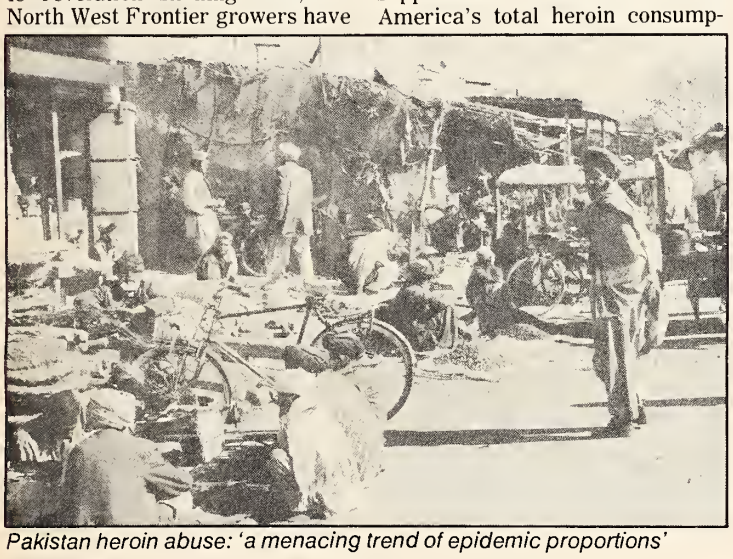
Responding to the Soviet invasion of Afghanistan and the Islamic revolution shaking Iran, the North West Frontier growers have now outstripped all their rivals in the production of inexpensive and high-quality heroin.

The change has come quickly, yielding immense profits for the lawless, tribal lands of the North West Frontier and causing mounting alarm both in Pakistan and the West. It has been brought about by the war in Afghanistan, which made it difficult for Pakistan's opium growers to transport their produce to Iran for refinement, and by the public executions of drug smugglers carried out under the Islamic law of Iran.

Local entrepreneurs have therefore established heroin laboratories with the assistance of foreign chemists operating with relative impunity in the tribal areas. The issue is complicated by the delicate politics of the frontier area, the presence of refugees from Afghanistan, and the sensitivity of the semi-independent tribal growers for whom opium is a valuable, traditional cash crop.

The North West Frontier now supplies more than half of North America's total heroin consumption and 80% of the heroin seized in Britain, a major distribution centre for the illicit West European trade. An estimated 80 tonnes (88.18 tons) of good-quality heroin base is believed to be ready for the Western markets in Pakistan after some bumper harvests.

North West Frontier: supplies more than half of North America's heroin



Pakistan heroin abuse: 'a menacing trend of epidemic proportions'

But Pakistan too must pay a human price. The United Nations International Narcotics Control Board says, over the past 18 months alone, heroin abuse in Pakistan has grown from almost negligible proportions into a "menacing" trend of "epidemic proportions" involving as many as 25,000 to 30,000 young people including university students.

Pakistan has recently imposed increased penalties for drug abuse and smuggling, and plans to reinforce a comprehensive program of crop substitution and eradication. The scheme, administered by the Pakistan Narcotics Control Board, is run with bilateral and multilateral assistance, giving the West an opportunity to exercise a measure of influence on the market forces affecting opium production.

West Germany has committed $3.4 million to an agricultural infrastructure development project intended to eliminate opium production in the North West Frontier region. It includes the irrigation of 3,400 acres of land to facilitate the cultivation of a wide range of crops new to the area. An expanded credit program and marketing network is planned to stimulate trade and help farmers with the purchase of fertilizers, improved seeds, and pesticides.

Overall responsibility for the project has been assigned to the UN Development Program. It is to improve livestock production through artificial insemination and disease control and to increase poultry production four-fold. Roads are being improved to help farmers transport their new crops to market. An important aspect of the scheme is the provision of clean water and the elimination of sources of water contamination.

Afghan refugees cross mountainous Pakistan border

Ireland — newest drug-transit point in Europe

By Sean Milmo

DUBLIN — Ireland has become a new transit point in Europe for the international drug trade in heroin and cocaine.

Irish police officers now claim that a massive increase in the amount of heroin, cocaine, and cannabis seized in the country indicates drugs are being channeled through Ireland.

Laurence Wrenn, the country's *Garda* (police) commissioner, told a conference of police officers: "It appears that Ireland is becoming a trans-shipment area for hard drugs on the international scene."

This development is linked to a big increase in drug abuse in Ireland itself (**The Journal**, April) and to the growth of organized crime in Dublin, where several gangs engaged in trafficking have recently emerged.

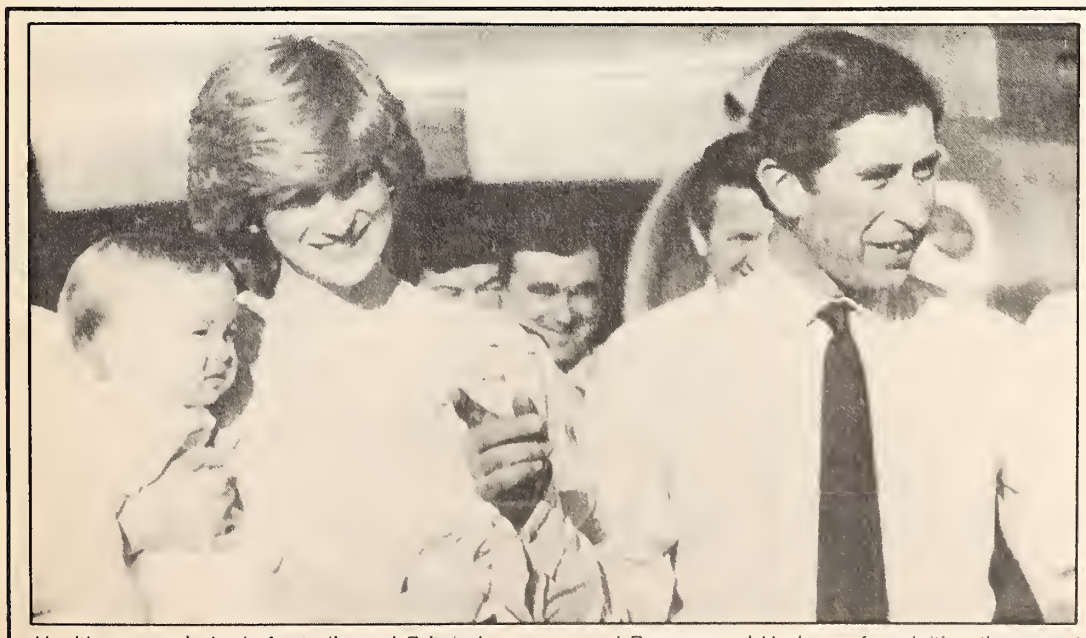
Mr Wrenn warned the meeting: "The 1982 crime figures, not yet published, will show that we have a vast increase in heroin and cocaine seizures over the 1981 figures. In addition, the numbers of people charged has correspondingly increased."

Police officers say hard drugs with an estimated street value in excess of £2 million (Cdn $3.8 million) were seized last year. On a per capita basis, this puts the country on a par with neighboring Britain where drugs with an estimated retail value of £59 million (Cdn $114 million) were seized by customs in 1981-82.

The biggest police success in recent years was the discovery 18 months ago of 1,600 kg (3,528 lb) of cannabis worth £5 million (Cdn $9.7 million) on a ship at Dublin docks.

Irish police believe most of the drugs they have seized have been en route to London and Amsterdam — the two major staging posts in Northern Europe's international drug trade. But drugs have also been seized at Rosslare, Ireland's direct sea-link terminal for France.

The drugs come mainly from the Far East and South America, with traffickers using Ireland as a communications link with other European countries to disguise the source of the material. (See The Back Page.)



Health groups in both Australia and Britain have accused Benson and Hedges of exploiting the recent Royal tour of Australia. Australian newspapers carried pages of full-color photographs of the Prince and Princess of Wales and Prince William alongside advertisements for the tobacco company. Canberra's cancer society chairman said it appeared that either the Royal Family was supporting the company or that the company was sponsoring the royal tour. David Simpson, of Action on Smoking and Health (ASH) in London, said the company's attempt to associate their product with the non-smoking Royal Family was disgraceful and inappropriate.

Israel drunk driving rates prompt on-spot BAL testing

TEL AVIV — Israeli police may now conduct tests to determine if a driver is under the influence of alcohol.

Although drunk driving has always been illegal in Israel, until mid-April police could arrest such drivers but could not force them to take blood-alcohol tests.

The new regulations were prompted by the ever-increasing rate of drunk driving in Israel. While more Israelis are driving under the influence of alcohol and other drugs, out of a total of 513,882 serious driving offences in 1981 (the last year for which figures are available) only 21 people were arrested for drunk driving.

The law allows for a breath analysis on the spot or at the nearest police station, or, if the driver requests it, blood and/or urine may be tested in a laboratory.

Drivers who refuse to take these tests face several options. They may lose their licence for up to 24 hours and have a notation made on their driving records. They may be charged with refusing to take the tests, and face a fine of 10,000 shekels (about $295 Cdn) — or tests may be taken against their will.

NEWS

MDs, druggists rate THC's value as antiemetic

MADISON, WI — Physicians and pharmacists in Wisconsin who have been treating chemotherapy-associated vomiting with THC (Delta-9 tetrahydrocannabinol, the chief active ingredient in marijuana) say they are satisfied with both the distribution program and the effectiveness of the drug.

Darold Treffert, MD, and David Joranson, of the state's Controlled Services Board, published the results of their evaluation of the United States National Cancer Institute (NCI) program in the *Journal of the American Medical Association* (Mar, 1983).

Under the NCI program, selected pharmacies in qualified hospitals dispense THC and approve the issuing of research orders by specific physicians experienced in cancer chemotherapy. In 1980 the US Food and Drug Administration approved the distribution of THC as an oral antiemetic.

Implementation of the Wisconsin program required no new legislation, and no new bureaucracy was created, the researchers noted.

Using questionnaires, hospital pharmacists and physicians were asked to rate the method of distributing THC, as well as its advantage over other antiemetics.

Of the pharmacists who responded, 78% said THC "probably had substantial advantages over other antiemetics." However, many noted there were problems with side-effects.

Most said they were satisfied with the distribution method because of the strict controls available.

The 35 doctors who responded were divided as to whether THC had an advantage over other commercial antiemetics. One-third said the drug had beneficial effects other than antiemesis. Two-thirds of the doctors noted adverse effects of THC, with sleepiness being the most common noted. And 20% said the adverse effects were severe enough to discontinue use of the drug.

Seventy-four per cent said the program should be maintained.

The study said doctors' perceptions of the drug's safety and effectiveness "closely paralleled formal research results reported in the scientific literature."

While the NCI program was being evaluated, "marijuana therapeutic legislation" was introduced to make marijuana and THC available for medical purposes. In order to avoid an unnecessary new layer of bureaucracy the legislation was amended and adjusted to the existing legal and administrative framework that did not require a new state regulatory board as exists in many states.

City dwellers rate pollution a higher risk than drugs

TORONTO — Downtown residents here believe environmental pollution is a greater health risk than such things as drinking, smoking, and drugs, suggests a University of Toronto survey.

Air and water pollution were the most frequent and often the first response to the question "what do you perceive as the greatest risk to health?" Smoking and drinking were sometimes not mentioned until the interviewers asked about them specifically, says Rhonda Love, PhD, co-director of the survey with Niall Byrne, PhD, associate professor at the university's department of studies in medical education.

Dr Love, director of health promotion at the university's department of behavioral science, says the findings are not surprising because pollution is more noticeable in downtown areas than other parts of the city. The 152 residents surveyed lived in the eastern downtown section of Toronto, a city of 3,000,000 people

"Public education has probably also raised the awareness of pollution as a health risk," she says.

However, Dr Love considers the general public is less concerned with lifestyle factors such as alcohol and cigarettes than are health professionals.

Nonetheless, those surveyed said they would contact their family doctor first about any health problem. This is peculiar because doctors are not pollution experts, she said at the university's second annual research day.

"Lifestyle factors receive most of the attention of professionals and public health, whereas the public seems to be concerned about those issues plus other environmental issues. Perhaps the task for health care workers is to understand that these wider environmental issues may take priority over the lifestyle concerns."

It may be important to take environmental factors into account when campaigns are launched to change lifestyles, Dr Love says.

The survey was funded by Health and Welfare Canada.

Drug and alcohol laws ineffectual until parents react: Chalmers

By John Carroll

SUSSEX, NB — Adults must set good role models for their children if drug and alcohol problems among young people are to be corrected, says the chairman of New Brunswick's Alcohol and Drug Dependency Commission (ADDC).

Everett Chalmers, MD, said here that Canada's drug problem is the result "of adults who drink and use drugs too much, of adults and governments who make money out of people who use alcohol and drugs, of adults whose business it is to try to persuade more people to use drugs more, of adults who stuff hockey and sporting broadcasts with liquor commercials, and a society that accepts it all.

"Until we, as parents, make a sincere effort to clean up this act, we doubt there will be any value in passing laws to prevent young adults from doing that which their parents and other adults have no intention of not doing."

The first line of attack on drug problems should continue to be in the home, he said. In a drug-rich environment, parents — in the final analysis — "are a child's main defence."

The family is the single most influential force in shaping the personality and character of the child, Dr Chalmers said.

"If you, as a parent, are unable to turn your children from drugs, who else will?"

Parents may find they have to change their lifestyles to present a better example to youth.

They should also become more informed about drugs, encourage adequate drug education, become active in community groups, and develop skills in chaperoning youth events at which they should provide good role models.

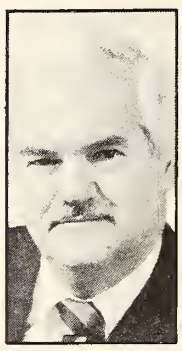
Youth should also become more active, ". . . having drug-free parties and developing positive and constructive opportunities to learn what life is all about."

The ADDC chairman said education and prevention are a priority of the commission. From factual information, young people in particular "will be able to make prudent and responsible decisions when they are confronted with the question of whether to use alcohol or drugs."

Chalmers: clean up act

CAF is striving for unity, financial independence says president Fitzpatrick

MEDICINE HAT, ALTA — The Canadian Addictions Foundation (CAF) wants to establish more unity among workers in the field and ensure their concerns are heard nationally, says its newly-re-elected president.



Fitzpatrick

Ed Fitzpatrick says this "grass-roots movement" won't develop fully unless there is more representation from British Columbia, Ontario, and Quebec. There are indications, however, that support is growing, he says.

Mr Fitzpatrick, who is coordinator of employee assistance programs for the Nova Scotia Commission on Drug Dependency, was re-elected to a one-year term at the annual regional symposium here in May. He was named CAF president in December after Ross Ramsey resigned the post. (**The Journal**, Feb).

The CAF's main objective in the next year will be to work toward establishing financial independence and a permanent staff to coordinate activities in the addictions field, he says.

In the meantime, the CAF works out of offices provided by the Alberta Alcoholism and Drug Abuse Commission (AADAC) and has access to its resources and staff (**The Journal**, Aug 1982). The agreement with the AADAC expires Nov 1, 1985.

Mr Fitzpatrick says he doesn't foresee too many problems raising money over the next few years because of the encouragement the CAF has received from within the field and from the general public.

"We have a lot of support out there and I think it's just a question of marshalling it," he told **The Journal**.

Membership in the CAF is increasing and an advisory planning committee has been set up to work toward improving the CAF's credibility, Mr Fitzpatrick says.

He also wants a National Drug Awareness week in 1984 because of the past success of various drug awareness weeks.

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Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

The Story of Wine

Number: 559.
Subject heading: Wine.
Details: 28 min, 16mm, color.
Synopsis: Baron Phillip de Rothschild narrates this historical travelogue about wine. He shows a wide variety of drinking vessels that have been used through the centuries and explains how vine growing came to France and why French wines are so good. The film shows how the vineyards are cared for; how the grapes are picked and crushed; and the art of the wine-maker, who through careful storage and blending, produces wine that can enhance the enjoyment of social gatherings.
General evaluation: Fair (3.3). The production quality was poor and the travelogue nature of the film tended to strongly endorse the use of wine. The assessment group said the film was entertaining, however, its use in alcohol education is probably limited to providing some historical background regarding the origins and uses of wine.
Recommended use: General audiences.

I'll Be Seeing You

Number: 560.
Subject heading: Drugs and youth.
Details: 11 min, 16mm, color.
Synopsis: The narrator, a drug pusher, tells a group of young people about the dangers of using narcotics, stimulants, and hallucinogens which he says can cause disease, perhaps insanity, even death. An enactment of a drug user's arrest is used to show that drugs are illegal and that people can get a permanent criminal record if arrested for their use. Parental over-reaction to their child's drug-use is shown. The film claims it is almost impossible to be cured of drug addiction.
General evaluation: Very poor (1.5). This dated film was poorly produced, and full of false information.
Recommended use: Should not be shown. Archives.

New Day Dawning

Number: 561.
Subject heading: Drugs and youth.
Details: 28 min, 16mm, color.
Synopsis: This is a collage of scenes and opinions about young people's drug use in the early 1970s. The film stresses the role of young people's sense of the influence of alienation and factors such as the Vietnam war, pollution, and starvation as forces contributing to drug use.
General evaluation: Poor (2.1). Although this film might have been meaningful years ago, it is now out-of-date and the message is no longer relevant.
Recommended use: Archives.

Another Little Drink

Number: 562.
Subject heading: Alcohol and alcoholism overview, alcohol and the family.
Details: 28 min, 3/4" video, color.
Synopsis: This videotape is apparently intended to raise awareness of alcohol use and alcoholism. The first part of the tape depicts, through animation, the effects of alcohol on the brain and behavior. Young people in pubs and at home are then interviewed, relating their own and their families' attitudes and experiences regarding alcohol and alcoholism. The interviewees stress the importance of obtaining help for the alcoholic, since "alcoholism is an illness that will not get right of its own accord."
General evaluation: Poor to fair (2.8). This tape appeared to be made for a local television station in England and does not seem applicable to wider audiences.

DEPARTMENT

New Books

by RON HALL

Psychiatric Illness in Physicians

. . . edited by Samuel E. D. Shortt

The articles that comprise this volume are an attempt to provide answers to the questions: How does emotional illness present in the physician? What are the etiological factors? How is it treated? How may it be prevented? One purpose of the book is to make those in need aware that assistance is both available and efficacious. A second theme is that a preventive approach to physician impairment is essential. One of the two papers devoted to alcoholism presents a study among male doctors in Scotland, and the other presents the results of a survey of 98 alcoholic physicians, who were members of Alcoholics Anonymous. Misuse of other drugs is discussed in three articles: narcotics addiction in physicians, physicians' use of mood-altering drugs, and drug addiction among physicians. One of these papers concludes that positive steps can be taken. Physicians of doctors should recognize that their patient's tendency to deny illness will make diagnosis difficult; and the patient's virtue of not troubling his doctor may lead to the wish to self-prescribe. The physicians of doctors should be alert to depression in their patients and must enquire directly about self-medication. It is felt that medical schools must assume greater responsibility for teaching their students that they represent a high-risk population for drug abuse.

(Charles C. Thomas, 2600 S First St, Springfield, IL 62717. 1982. 329 p. $34.75. ISBN 0-398-04638-7)

The Analysis of Cannabinoids in Biological Fluids

. . . edited by Richard L. Hawks

This United States National Institute on Drug Abuse research monograph describes a variety of methodologies for cannabinoid analyses. The methodologies are in response to the need for less-expensive and more-reliable tests for use by the armed forces, civilian law enforcement agencies, and private industry where concern exists for the impact of marijuana use on critical job performance. The discussion of methodologies includes immunoassay, gas chromatography, gas chromatography/mass spectrometry, and high-performance liquid chromatography. The volume is intended to be of use to basic researchers in the fields of biomedical and forensic science, where the availability of reliable, accurate, and accessible quantitative assays is critical to a better understanding of issues of marijuana abuse.

(US Government Printing Office, Washington, DC 20402. 1982. 141 p. $5. S/N 017-024-01151-7)

Other books

The Recovery Handbook Or What To Do After You Say "I Quit" — Rosellini, Gayle and Worden, Mark. DIN Publications, Phoenix, 1981. What a recovering alcoholic can do to facilitate the recovery process; includes sections on nutrition, stress management, and other positive living skills. 48 p. DIN Publications, PO Box 5115, Phoenix, AZ 85010. $1.50 ISBN 0-89230-092-2.

Handbook of Rural Community Mental Health — Keller, Peter A. and Murray, J. Dennis (eds). Human Sciences Press, New York, 1982. Mental health in rural areas; mental health services; professional issues in the rural community. References, index. 262 p. Human Sciences Press. 72 5th Ave, NY, NY 10011. $29.95. ISBN 0-89885-065-7.

Confronting Alcohol Problems in Your Congregation — Adams, Bob H. CompCare Publications, Minneapolis, 1982. Guidelines for clergy to recognize and aid alcoholics in their congregations. 20 p. CompCare Publications, 2415 Annapolis Ln, Minneapolis, MN 55441. $1.50. ISBN 0-89638-054-8.

Who's Raising the Family? — Delaine, John K. Wisconsin Clearinghouse, Madison, 1981. A workbook for parents and children; teachable skills for children; parenting methods; parental stress; television; talking about alcohol and other drugs; and developing alternatives. 74 p. Wisconsin Clearinghouse, 1954 E Washington Ave, Madison, WI 53704. $4.85.

Coping in Medical School — Virshup, Bernard. Health Sciences Consortium, Chapel Hill, 1981. Medical school as change and stress; accepting and limiting responsibility; attachment needs; independence, individualism, and identity; self-esteem; internal critics and guilt; security needs; actualizing potential; anger; depression; preventing physician impairment. 130 p. Health Sciences Consortium, 200 Eastowne Dr, Ste 213, Chapel Hill, NC 27514. $12.95. ISBN 0-938938-02-9.

Drug Use Among Native American Youth: Summary of Findings (1975-1981) — Oetting, E.R. and Beauvais, Fred. Western Behavioral Studies, Fort Collins, 1982. Cultural identification and drug use; acquisition of drug exposure; drug use by children. Tables, figures. 122 p. Western Behavioral Studies, department of psychology, Colorado State University, Fort Collins, CO 80523.

The Influence of Alcohol and Drugs on Driving — World Health Organization Regional Office for Europe, Copenhagen, 1981. Report on a WHO Ad Hoc Technical Group; review of drugs with a known effect on driving; biological and analytical studies; epidemiology; monitoring the effect of legislation; psychosocial factors in the consumption of alcohol, and medical and illicit drugs. References. 27 p. Canadian Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, ON K1Z 8N8. ISBN 92-890-1204-8.

Opiate Receptors, Neurotransmitters, and Drug Dependence: Basic Science - Clinical Correlates — Stimmel, Barry (ed). Haworth Press, New York, 1981. Current clinical concepts of dependence, tolerance, and withdrawal; opiate receptors and endorphins; alcohol and the opiate receptor; opioids and psychological disorders. 129 p. Haworth Press, 149 5th Ave, NY, NY 10010. $25. ISBN-0-86656-103-X.

DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Fifth World Conference on Smoking and Health — July 10-15, Winnipeg, Manitoba. Information: Kurt Baumgartner, Box 8159, Terminal PO, Ottawa, Ontario K1A 0C1.

24th Annual Institute on Addiction Studies — July 17-22, Hamilton, Ontario. Information: Alcohol and Drug Concerns Inc, 15 Gervais Dr, Ste 603, Don Mills, ON M3C 1Y8.

Summer Course in Addictions (Fundamental Concepts) — July 18-21, Toronto, Ontario. Information: Barbara MacPherson, Administrative Coordinator, School for Addiction Studies, Addiction Research Foundation (ARF), 8 May St, Toronto, ON M4W 2Y1.

The Annual Conference of the Canadian Mental Health Association — Aug 3-6, St John's, Newfoundland. Information: Dr Edna Turpin Downey, Canadian Mental Health Association, Newfoundland Division, PO Box 5788, St John's, NF A1C 5X3.

International Doctors in Alcoholics Anonymous Annual Meeting —Aug 4-7, Vancouver, British Columbia. Information: Dr Lewis Reed, IDAA Secretary, 1950 Volney Rd, Youngstown, Ohio 44511.

5th Biennial Canadian Conference on Employee Assistance Programs, Input '83 — Aug 9-12, Toronto, Ontario. Information: Input '83 Headquarters, Professional and Management Development, Humber College, Box 1900, Rexdale, ON M9W 5L7.

Royal College of Physicians and Surgeons Annual Meeting — Sept 19-22, Calgary, Alberta. Information: Robert A. Davis, associate director, Office of Fellowship Affairs, Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

Fundamental Concepts Course in Addictions — Sept 19-22, 1983, Jan 16-19, 1984, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Detox Training Program (Non Medical) — Sept 19-23, Oct 17-21, Nov 14-18, Toronto, Ontario. Information: Diane Hobbs, Detox and Rehab Programs, ARF, 33 Russell St, Toronto, ON M5S 2S1.

Introductory Addictions Management Course — Sept 26-28, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

33rd Annual Meeting of the Canadian Psychiatric Association — Sept 28-30, Ottawa, Ontario. Information: Canadian Psychiatric Association, Ste 103, 225 Lisgar, Ottawa, ON K2P 0C6.

College of Family Physicians of Canada, Ontario Chapter, 21st Annual Scientific and Business Meeting — Oct 2-5, Toronto, Ontario. Information: Ontario Chapter, College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

Basic Counselling Skills Course — Oct 3-7, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Addictions '83 International — Oct 12-14, Ottawa, Ontario. Information: C. Cashman, Coordinator, Postgraduate Board, Royal Ottawa Hospital, 1145 Carling Ave, Ottawa, ON K1Z 7K4.

Managing The Information Function — A Joint Annual Conference of Substance Abuse Librarians and Information Specialists, Librarians and Information Specialists in Addictions — Oct 18-21, Toronto, Ontario. Information: Ron Hall, Information and Promotion, ARF, 33 Russell St, Toronto, ON M5S 2S1.

Pharmacology and Drug Abuse Course — Oct 31-Nov 2, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Behavioral Interventions Course — Nov 14-16, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Strategies for Coordinating Community Services Workshop — Nov 21-23, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Group Therapy Course — Jan 9-13, 1984, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Perspectives on Employee Assistance Programming Course — Jan 23-26, 1984, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Pharmacology and Drug Abuse Course — Feb 6-8, 1984, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May Street, Toronto, ON M4W 2Y1.

Prevention Strategies Workshop — Feb 20-22, 1984, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Workshops 1983-84: Employee Assistance Program Management Update — Feb 22-24, 1984, Toronto, Ontario. Information: Yvonne Johns, department head, department of Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

1984 Canadian Addictions Foundation Atlantic Regional Conference, Families and Drug Dependencies New Problems, New Challenges — Apr 29-May 3, 1984, Halifax, Nova Scotia. Information: Nova Scotia Commission on Drug Dependency, 5668 South St, Halifax, NS B3J 1A6.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: Mr J. Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th Floor, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

JCAH Alcoholism Clinical and Treatment Planning Requirements Workshop — July 13-15, Philadelphia, Pennsylvania. Information: The National Association of Alcoholism Treatment Programs, Inc, 2082 Michelson Dr, #200, Irvine, California 92715.

Student Assistance Programming — July 18-22, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Issues of Sexuality in Alcohol/Drug Dependency Counselling — July 20-22, Nov 17-19, Center City, Minnesota. Information: Marilyn Brissett, Continuing Education department, Hazelden Foundation, Center City, MN 55012.

World Congress on Mental Health — July 22-28, Washington, DC. Information: World Federation for Mental Health, #107-2352 Health Sciences Mall, University of British Columbia, Vancouver, BC V6T 1W5

Sexuality, Intimacy and Alcohol/Drug Dependence — July 25-26, Indianapolis, Indiana. Information: Kay Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

New Jersey Summer School of Alcohol and Drug Abuse Studies — July 31-Aug 5, New Brunswick, New Jersey. Information: Gail Gleason Milgram, Education and Training Division, Center of Alcohol Studies, Smithers Hall, Rutgers University, New Brunswick, NJ 08903.

Athletes, Alcohol, and Drugs: A Coaches' Clinic — Aug 1-5, St Peter, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

Seminar on Children and Chemical Abuse — Aug 1-5, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

National Association of Alcoholism and Drug Abuse Counselors (NAADAC) — Aug 6-10, Houston, Texas. Information: National Association of Alcoholism and Drug Abuse Counselors, 951 S George Mason Dr, Arlington, Virginia 22204.

7th Annual Summer Institute of Drug Dependence — Aug 14-19, Colorado Springs, Colorado. Information: Dan Barmettler, director, The Institute for Integral Development, PO Box 2172, Colorado Springs, CO 80901.

Prevention-Outlook for the '80s — Aug 18-20, Myrtle Beach, South Carolina. Information: Cathy McKinney, Charlotte Drug Education Center, 1416 E Morehead St, Charlotte, North Carolina 28204.

Prevention Skills For Religious Organizations — Aug 22-23, Center City, Minnesota. Information: Marilyn Brissett, Continuing Education department, Hazelden Foundation, Center City, MN 55012.

Alcohol and Drug Problems Association of North America 34th Annual Meeting — Aug 28-Sept 1, Washington, DC. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

7th Annual Summer Institute on Drug Dependence — Aug 28-Sept 2, Colorado Springs, Colorado. Information: Dan Barmettler, Institute for Integral Development, PO Box 2172, Colorado Springs, CO 80901.

Training Program For Alcoholism Counselling — Sept 10, 1983-Jan 21, 1984, Jan 31, 1984-June 2, 1984, Amityville, New York. Information: The Institute of Alcohol Studies at South Oaks, PO Box 426, Amityville, NY 11701.

Drug and Alcohol Issues Symposium — Sept 14-16, Dayton, Ohio. Information: Thomas Prugh, WORAC, 379 W 1st St, Ste 300, Dayton, OH 45402.

Drugs in the Workplace: "A Man-Made Disaster." — Sept 19-20, Alexandria, Virginia. Information: Lee Dogoloff, American Council for Drug Education, 6193 Executive Blvd, Rockville, Maryland 20852.

Student Assistance Programming — Sept 19-23, Milwaukee, WI. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

6th Annual Current Concerns in Adolescent Medicine — Growth Disorders In Adolescence, Threats to Adolescent Health — Sept 22-23, New York, NY. Information: Ann J. Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

Alcoholism: Etiology, Diagnosis and Treatment — Sept 23, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

2nd Annual Conference of the National Federation of Parents for Drug-Free Youth — Sept 26-28, Washington, DC. Information: National Federation of Parents for Drug-Free Youth, 1820 Franwall Ave, Ste 16, Silver Spring, Maryland 20902.

Group Counselling Skills for Alcohol/Drug Clients — Sept 26-28, Indianapolis, Indiana. Information: Kay Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

National Youth Workers Conference — Sept 26-29, Chicago, Illinois. Information: The National Youth Work Alliance, 1346 Connecticut Ave, NW, Washington, DC 20036.

Health and Addictions Conference — Sept 29-Oct 3, New York, NY. Information: Institute for Integral Development, PO Box 2172-J, Colorado Springs, Colorado 80906.

12th Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism — Oct 3-7, Minneapolis, Minnesota. Information: ALMACA, 1800 N Kent St, Ste 907, Rosslyn, Virginia 22209.

Treating Cocaine Dependence — Oct 5-6, San Francisco, California. Information: Lee Dogoloff, American Council for Drug Education, 6193 Executive Blvd, Rockville, Maryland 20852, or Joan Zweben, Pacific Institute for Clinical Training, Education and Consultation, 714 Spruce St, Berkeley, CA 94707.

3rd Annual Primary Prevention Conference "Kid's Stuff II" — Nov 1-3, Austin, Texas. Information: Peggy Frias-Lynch Prevention Services, Texas Commission on Alcoholism, 201 E 14th St, 8th fl, Austin, TX 78701.

American Society of Criminology 35th Annual Meeting — Nov 9-12, Denver, Colorado. Information: Joseph E. Scott, department of Sociology, Ohio State University, Columbus, Ohio 43210.

ADPA 1983 Western Regional Conference — Nov 13-16, Los Angeles, California. Information: Eric Scharf, Alcohol and Drug Problems Association, 1101-15th St, NW, Ste 204, Washington, DC 20005.

8th Southeastern Conference on Alcohol and Drug Abuse — Nov 30-Dec 4, Atlanta, Georgia. Information: Barbara Turner, Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, GA 30342.

Abroad

9th International Conference of the International Association for Accident and Traffic Medicine — July 10-15, Mexico. Information: Dr R. Andreasson, IAATM, PO Box 10043, 5-100 55 Stockholm 10, Sweden.

8th Institute on Drugs, Crime, and Justice in England and America — July 11-15, London, England. Information: Institute on Drugs, Crime and Justice, School of Justice, The American University, Washington, DC 20016.

7th World Congress of Psychiatry — July 11-16, Vienna, Austria. Information: Congress Team International, PO Box 9, A-1095 Vienna.

Australian Medical Society on Alcohol and Drug Related Problems 3rd Annual Conference — July 31-Aug 7, Cairns North Queensland, Australia. Information: Conference Organizers, PO Box 155, Civic Square ACT, 2608, Australia.

Middle Eastern Summer Institute on Drug Use (MESIDU): Techniques, Strategies, Concepts, and Options — Sept, Jerusalem Israel. Information: Stan Einstein, PhD, Director, MESIDU, 113/41 East Talpiot, Jerusalem, Israel.

International Conference on Alcoholism — Sept 26-30, Reykjavik, Iceland. Information: International Council on Alcohol and Addictions (ICAA), Case postale 140, 1001 Lausanne, Switzerland.

13th International Institute on the Prevention and Treatment of Drug Dependence — Oct 10-14, Oslo, Norway. Information: ICAA, Case postale 140, 1001 Lausanne, Switzerland.

8th World Congress of Acupuncture — Oct 12-16, Seoul, Korea. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

9th International Conference on Alcohol, Drugs and Traffic Safety — Nov 13-18, San Juan, Puerto Rico. Information: T-83 Secretariat, GPO Box 5067, Medical Sciences Campus, San Juan, Puerto Rico 00936.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

2nd International Congress on Drugs and Alcohol — Dec 18-22, Tel Aviv, Israel. Information: Congress Secretariat: Peltours Ltd, Congress department, PO Box 394, Tel Aviv, 61003 Israel.

An International Conference on Alcoholism and Drug Addiction — Apr 2-7, 1984, Canterbury, England. Information: Conference Secretary, Broadway Lodge, Oldmixon Rd, Weston-super-Mare, Avon, BS24 9NN, England.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: Dr H. D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

Overview presents 'a grim picture'

Colombo Plan wrestles soaring drug abuse

Since 1950 The Colombo Plan has existed to improve socio-economic conditions in Asia and the Pacific. In 1973, however, the plan expanded its focus by establishing the Drug Advisory Program (DAP), coordinated by attorney Pio Abarro, who is based in Colombo, Sri Lanka. In a January address to the 10th Biennial Summer School on Alcohol, Drugs, and Chemical Dependency in New Zealand, Mr Abarro said his responsibility as drug adviser to the DAP is to "consult with governments, and help develop cooperative programs designed to eliminate the causes and ameliorate the effects of drug abuse."

Mr Abarro was the 1979 recipient of the Edward Browning Achievement Award for alleviation of addiction (The Journal, Mar, 1980). The Journal presents Mr Abarro's comments in summary form.

Abarro

My presentation will cover only the developing countries of the Colombo Plan whose problems and responses have not been publicized much outside the region.

The Colombo Plan region encompasses the three largest opium-producing areas in the world.

The 'Golden Triangle' area, where Thailand, Burma, and Laos meet, produces an estimated 500 to 600 tons of opium annually (**The Journal**, Mar, 1981).

The 'Golden Crescent' area — the opium-growing regions of Pakistan, Iran, and Afghanistan — produces 700 to 900 tons of opium annually.

India produces about 90% of the world's opium supply for legitimate medical requirements — 900 to 1,000 tons annually. With recent demands down to 500 tons per year, there is an accumulated stockpile of unsold opium of approximately 2,000 tons.

There are many clandestine laboratories in the region which convert opium to morphine and heroin. It is estimated there are from nine to 13 in the Golden Triangle, and from eight to 20 in the Golden Crescent area. Some laboratories have been discovered and dismantled in India, Sri Lanka, Nepal, and in the Thai-Burma-Malaysia border areas.

Illegal cultivation of cannabis has supplemented wild growth in many countries following an increase in both local and export market demands.

On the demand side this region also comprises the biggest drug-dependent population in the world.

Here are some approximate estimates of the problem:

- In Pakistan there are 450,000 to 800,000 drug-dependent people. Two years ago there were no heroin addicts reported. Now there are 25,000 to 30,000.
- Thailand has 500,000 to 600,000 drug dependents, more than 70% of them on heroin, and most of these aged 20 to 24 years.
- Burma's 100,000 reported opium addicts consume nearly 100 tons of the estimated 300 to 400 tons of opium produced there annually.
- In Malaysia, only 36,000 of the estimated 250,000 people involved with drugs have been identified by the central registry system in Penang (**The Journal**, Aug, 1980).

An overview of drug abuse in Colombo Plan countries presents a grim picture. Except for Bhutan, drug abuse is increasing in most parts of the region, as is the number of drug-traffic transit areas.

Iran reported seizures of more than 19 tons of opiates in the first half of 1981, and in the same period, Afghanistan reported seizure of more opium than in all of 1980. Illicit drugs have also been seized in new areas of the region — Fiji, Papua New Guinea, and Samoa.

Many countries report a growing increase in psychotropic drug abuse, and multiple-drug abuse is becoming frequent in many parts of the region. Control of psychotropic drug misuse is a more-difficult and complex problem, since these drugs are easily available for medical use.

A new phenomenon in Southeast Asian countries is the abuse of cough syrups and inhalants or volatile substances, which are easy to obtain. This problem is as difficult to control as is the abuse of psychotropic drugs.

Hashish and hashish oil are becoming increasingly more available to users, primarily young people in urban centres. Traffic in other drugs, like cocaine, is small but increasing.

Trafficking

Drug traffickers are becoming more sophisticated and innovative, and make maximum use of transit possibilities. They constantly change the nationalities of their couriers, using many people who carry small amounts so as to avoid detection, reduce losses if apprehended, and avoid stringent penalties when caught.

A new phenomenon in illicit heroin trafficking from the Golden Crescent has also emerged. Seizures of 60 to 110 kg of almost pure heroin at a time (totalling more than 800 kg in the last six to nine months) alarmed many in the international drug community, and several heroin-processing laboratories were discovered in the border areas of Pakistan and Afghanistan. The price per kg for Golden Crescent heroin has dropped to between $600 and $800 US compared to between $10,000 and $12,000 US for Golden Triangle heroin, indicating greater availability.

Against this background, I would like to mention some of the counter-measures and responses of the Colombo Plan member countries to the drug abuse problem.

In the late 1960s and early 1970s the sudden upsurge of drug abuse in some member countries caused the governments of the region to re-examine their responses to the drug phenomena. Drug abuse began to affect the most vital resource of many countries — the youth (**The Journal**, Mar, 1980). Many governments saw the socio-economic effects of drug abuse as a danger to developing countries, and some countries regarded the problem as one involving the security of the state.

Harsh penalties

In 1972 the Philippines passed a Dangerous Drugs Law, which provided the death penalty for drug trafficking and manufacturing and allowed the state to confiscate property used in drug production or cultivation.

Several regional countries have adopted capital punishment for major drug law violations — Malaysia, Singapore, Burma, Indonesia, Iran, the Philippines, Korea, Thailand, and Brunei. The penalty has been carried out in Singapore, Iran, Thailand, and the Philippines.

Many regional states adopt tough penal laws because drug traffickers and smugglers are regarded as economic saboteurs.

Some social scientists question the effectiveness of capital punishment, but at least we are sure the penalty prevents recidivism.

Several countries allow no bail for major drug law violations. In the Philippines, though, provisions for speedy prosecution and trial of drug cases mandates the termination of a case within two to three months.

However, in Malaysia and Singapore, major drug law violators may be ordered to be confined for up to two years (on signature of a minister) without prosecution, as a preventive measure.

New legislation in other countries provides for seizure of cars, articles, ships, aircraft, buildings, land, and assets in favor of the government. In some countries, possession of drug paraphernalia or marijuana seeds is a criminal violation which carries a prison sentence.

Importing of marijuana or opium seeds is also controlled in the Philippines and Singapore. Even wearing a shirt with a marijuana design on it is a criminal violation. In the Philippines the wearer becomes liable for prosecution. The rationale is to deglamorize drugs.

Flogging is also part of the penalty for drug law violations in Malaysia, Brunei, Singapore, and some Muslim countries.

The new legislations of regional countries show a general trend toward strengthening of narcotic law enforcement bodies. They are creating central or national coordinating organizations at ministerial levels that may supervise, coordinate, or direct not only narcotics law enforcement activities, but also all aspects of treatment and rehabilitation, prevention, education, information, training, and research relating to drugs.

These bodies have been found to be effective in responding quickly to agencies' funding needs and in making policy decisions regarding prevention and control of drug abuse.

Moreover, they act as the central or national agency responsible for the implementation of international (regional) treaty obligations of countries in relation to the Single Convention on Narcotic Drugs of 1961, the 1972 Protocol (amending the 1961 Convention) and the 1971 Convention on Psychotropic Substances. They also serve as the liaison agencies to international organizations like the United Nations, the International Narcotics Control Board, Interpol, the Colombo Plan, and the national, central, narcotic bodies of other countries.

A growing problem of alcohol abuse has also been reported in several Colombo Plan countries. Changes in the political scene in Afghanistan, Iran, and Pakistan have introduced significant and dramatic changes in social policy regarding drugs, including alcohol. Under Islamic law, Iran banned alcohol and poppy cultivation.

Pakistan has done the same. All licenced opium premises there have been ordered closed down (**The Journal**, Jan, 1980, June 1979). Recently, Pakistan approved a maximum sentence of life imprisonment — and in some cases flogging — for drug law violators.

The penalties in the region generally for the drug trafficker, smuggler, manufacturer, and pusher are both stringent and draconian.

In the Maldives, drug law violators can be banished to one of the many atolls until their term expires.

In addition to stringent laws banning opium poppy cultivation, Thailand, Burma, and Pakistan have begun crop substitution and community development programs to help people whose livelihood depended on this plant (***The Journal***, May).

Mandatory treatment

During the last decade many countries have come to view drug dependents as sick or maladjusted individuals needing treatment rather than as criminals, and they have tried various approaches to deal with their needs.

Although voluntary treatment for the drug-dependent is still available, the Philippines, Malaysia, Singapore, and Burma provide compulsory treatment and rehabilitation (and registration in Burma) for those who come in contact with the law (**The Journal**, Mar, 1980).

In the Philippines every drug-dependent person who is brought before the courts is ordered to be confined in a treatment centre of his choice. However, anyone who escapes from the treatment centre is considered a criminal violator and the court may issue an order for re-commitment or arrest.

In Singapore, anyone found to be an addict may be ordered to undergo compulsory treatment and rehabilitation for a period of from six to 18 months. Upon release he is placed on compulsory supervision and is liable to a mandatory three-year prison term for violating supervisory regulations (**The Journal**, Sept, 1982).

Drug dependence is no longer a crime in Burma, but failure to register and take medical treatment is a violation punishable by six months' to six years' imprisonment.

Effective control

The Drug Advisory Program (DAP) has geared its efforts to help member countries to develop effective national drug abuse prevention and control programs. Since its inception in 1973, the DAP's thrust has been in the following main areas:

- Advising and supporting member governments in creating public awareness of the dangers of drug abuse;
- Assisting governments in updating their drug laws, and in establishing special narcotics units and national narcotics coordinating bodies;
- Encouraging and supporting the formation of community-based, non-government, voluntary organizations;
- Development of human resources and expertise of narcotic officials of member countries; and,
- Development and strengthening of local, regional, and international cooperation in the various government departments directed toward the prevention and control of drug abuse.

Member countries' programs are drawn up on the basis of individual country needs, desires, and interests. The DAP helps member countries in sponsoring and organizing conferences on prevention and control of drug abuse.

In the past nine years the Colombo Plan Bureau has cooperated in seminars, workshops, and conferences in preventive education and information, law enforcement, training and research, treatment and rehabilitation, and planning programs.

The DAP operates a modest study fellowship, giving assistance for training of narcotics officials by means of study exchange fellowships and cross-posting arrangements.

The DAP has consistently encouraged and supported non-government organizations (NGOs) in its efforts in control and prevention of drug abuse. It organized the First International Conference of Non-Governmental Organizations in Jakarta, Indonesia in 1979. Since then it has become an annual project of the DAP.

One of the conferences resulted in the establishment of a Federation of Non-Government Organizations Against Drug Abuse, which has helped encourage coordination of national NGOs and voluntary bodies in member countries, and also strengthen cooperation between government agencies and private bodies for more effective efforts against drug abuse.

THE BACK PAGE

Begin leaves trail of hope and speculation

Cigarette tax hike in the air

WINNIPEG — Experts are skeptical that Health Minister Monique Begin's proposal to hike dramatically the tax on cigarettes and thereby reduce consumption will be put into effect.

If it is, it may work better than she anticipates.

Ms Begin told the Fifth World Conference on Smoking and Health here that she would seek an increase in the federal tobacco tax which would result in a 30% increase in the price of cigarettes. She predicted the increase would likely result in a 10% decrease in cigarette consumption across Canada.

Begin

Ms Begin's announcement drew widespread media and public attention, but left some confusion.

While conference delegates were generally pleased by Ms Begin's initiative, they were somewhat doubtful about its future.

Kurt Baumgartner, secretary general of the conference, said: "I won't believe that increase until I see it."

He suggested Ms Begin's proposal was "spur of the moment" and perhaps personal lobbying, as federal finance officials were not aware of any request from Ms Begin to Finance Minister Marc Lalonde.

Next month: More from the Fifth World Congress on Smoking and Health

In fact, they said, plans to raise the federal tax on tobacco products by about 15.5% in September were already in progress.

Richard Gilbert, PhD, author of a study on the effect of price on cigarette consumption for the Ontario Council of Health Task Force on Smoking, said research shows the move proposed by Ms Begin would likely have an even greater effect than predicted.

Dr Gilbert, also a columnist for **The Journal**, said research shows a 30% increase in the price of cigarettes should result in a 20% decline in consumption (**The Journal**, Apr 82).

Dr Gilbert said on balance he was in favor of a price increase.

"In my view, it is the only sure and effective way of reducing consumption, but I have some reservations about applying it."

Most people acquire the habit when they are not fully responsible for their actions — in their teenage years, Dr Gilbert said. "Society is largely to blame for getting them hooked, and it may be particularly mean to want to charge them more for their habit."

On the other hand, he said, a price increase would be especially effective with young people, as they generally have less money.

Dr Gilbert pointed out that recent large increases in provincial taxes on cigarettes across Canada will likely produce this year the first significant decline in per capita cigarette consumption since the late 1960s. For example, said Dr Gilbert, provincial taxes on cigarettes in Ontario have risen by more than 70% in the last 15 months with very little publicity.

In a press conference at the meeting, Ms Begin said she would like to introduce stronger measures to curb the use of tobacco in Canada — but said she and the government face extreme pressure from some segments of society.

She said tobacco companies financially support many activities in Canada, especially sports. "It is a fact that (sports) appeals to the vast majority of Canadians," she said. "We're talking money here."

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The Journal

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Device is inexpensive and accurate

Dipstick simplifies test for alcohol

By Terri Etherington

TORONTO — A simple and inexpensive method of determining the alcohol level in body fluids has been developed here by researchers at the Addiction Research Foundation (ARF).

The alcohol dipstick, a three-inch cellulose strip with a small reagent paper pad at one end, turns a pink-red color when dipped in saliva, urine, or blood serum containing alcohol. The dipstick can be matched against a six-point color-coded scale: the darker the hue the higher the alcohol content.

The test can be done by anyone, anywhere, when an approximate measure of alcohol content will suffice, Yedy Israel, PhD, head of biochemical research, and Bhushan Kapur, PhD, director of clinical laboratories, at the ARF, told **The Journal**.

The test gives an accurate reading of the range of alcohol on a six-point scale from 0% to 0.16% or more. Since the dipstick does not give a precise percentage it will not replace roadside breath tests or other tests requiring specific measurements for legal purposes.

Drs Kapur and Israel, also of the faculty of medicine, University of Toronto, said the dipstick will be particularly useful in emergency rooms and doctors' offices for quick assessment of a patient's alcohol consumption, in alcohol treatment centres as a measure of patient compliance, and in any setting where more sophisticated analysis equipment is not readily available.

Interest in the dipstick has been shown not only by physicians and treatment centres but also by correctional institutions to monitor alcohol consumption by inmates on day passes, by the beverage industry for public education, and by road and traffic safety groups as an initial screening device for impaired drivers.

The dipstick combines a competitive inhibitor (pyrazole) with alcohol dehydrogenase and other reagents. When dipped in a solution containing alcohol, it yields the pink-red color. Different concentrations of ethanol yield, after a standard time (one minute), different intensities of color. These can be quantified either by visual comparison with the graduated scale or by reflectance spectrophotometry for a more precise measurement.

In field trials, 1,500 patient samples have been tested.

"When we compared the results of the dipstick method with other techniques, there was a 99% correlation," Dr Kapur said, and the incidence of false positives was extremely low.

Alcohol levels as low as 0.01% to 0.02% can be measured by the dipstick. (The legal limit for drivers in Canada is 0.08%).

Two research developments are involved, the scientists say: the slowing down of the reaction between dehydrogenase and alcohol by adding the inhibitor allows the reactions to be measured over a wide range of alcohol concentrations; and the expression of the reaction product "as a color in a solid support system" is a departure from traditional measurements.

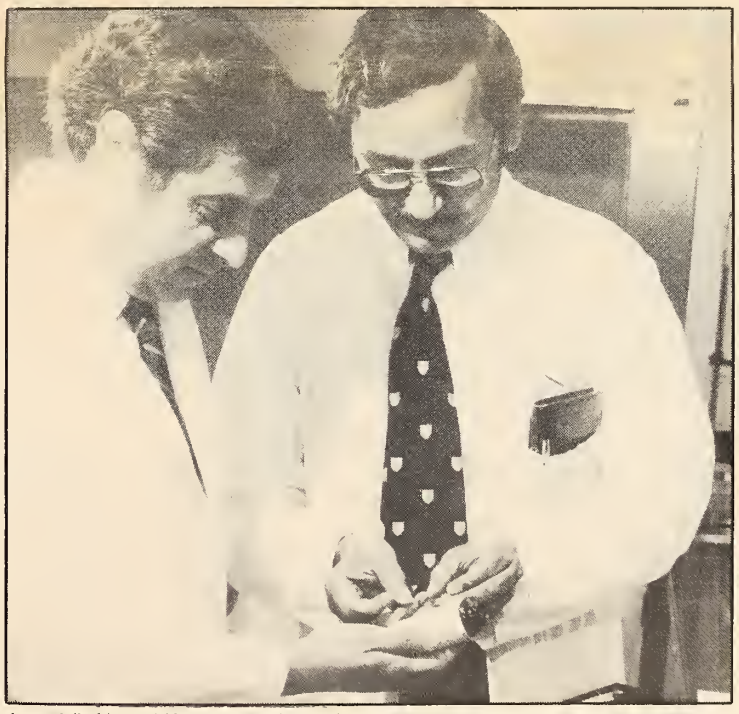
"This is a breakthrough which can be improved, given time," Dr Kapur said. Separate scales are provided for blood, urine, and saliva, but the researchers expect eventually all three tests will be combined on one dipstick with one graduated color scale.

A nine-point scale ranging from 0% to 0.25% or greater has also been tested and the researchers say the range may be altered to suit many different applications by varying the relative concentrations of the competitive inhibitor to the dehydrogenase.

The availability of a cheap, fast method may mean more alcohol level testing will be done, the investigators suggested.

"Between 15% and 20% of morbidities in general hospitals are alcohol related, but testing for alcohol is not done at levels that would be warranted given these morbidities."

Marketing of the dipstick, aimed at making it commercially available and widely distributed, is being investigated. The researchers say it will be particularly attractive to smaller hospitals and clinics in developed countries, and to developing countries, where more sophisticated equipment is not available.



Israel (left) and Kapur: graduated color scale, easy visual comparison

BC alc/drug group integration finalized as budget cuts hit

VANCOUVER — The integration of the British Columbia Alcohol and Drug Commission into the ministry of health here will have no negative impact on either treatment or research in the province, say officials from both the ministry and the commission.

However, the July 7 Act to repeal the Alcohol and Drug Commission Act comes at a time of severe budget restraint in BC and a government promise to cut the civil service by 20%.

The commission, called Alcohol and Drug Programs for about a year now, was at one time responsible for all of BC's substance abuse prevention and treatment programs.

Eric Denhoff, a spokesman for the health ministry, said the Act will have no direct effect on staff or budget.

However, the detailed budget estimates show estimated costs for alcohol and drug "program management" cut by 18% this year. The overall budget for alcohol and drugs has been trimmed 1% to $18,505,000 this year from $18,676,000.

BC docs want methadone maintenance clinics re-opened page 2

Alcohol and Drug Programs executive director John Russell was on vacation at the time the legislation was announced. Contacted at home, he said he is aware of the content of the legislation but declined comment until the bill is introduced in the legislature.

However, acting executive director Carl Stroh, PhD, echoed Mr Denhoff. He told **The Journal** the change "has no effect whatsoever on treatment or research programs in the province . . . All of the functions that were carried on by the commission are now carried on by the ministry of health."

The commission reached the height of its power when BC introduced its controversial compulsory heroin treatment plan (**The Journal**, Aug 78, Jan 79). After a long, back-and-forth court battle, the province finally established its

(See — New — page 2)

INSIDE

NEWS

Athletes should warn of drug dangers not sell beer, says sportscaster

By Harvey McConnell

PHILADELPHIA — Professional athletes in the United States should teach young people about the dangers of chemical dependency instead of touting beer in television commercials, charges television sportscaster and commentator Howard Cosell.

Only then will young people learn chemical dependency "is one of the hard core questions in the sports world in this country today," and that many athletes have been successfully rehabilitated.

"They deserve to be educational role models who can help your children and mine, maybe all of us at any age," Mr Cosell told the National Conference on Alcoholism and the Family here.

A decade or so ago the attitude of the sports world to drug and alcohol use was simplistic — the problems are in society and athletes are no different from the rest of society, nor should they be.

Mr Cosell said such an argument doesn't hold up. It is more than just an average problem "with those who invade the American home as role models or surrogate parents.

"When they have the kind of public posture that athletes do, there is a concomitant responsibility to the American public to formulate programs of education, detection, and rehabilitation within the sports that will cope with this problem and, maybe, in the long run, defeat this problem."

Officials of major league baseball were aware in the early 1970s of the successful efforts by former Brooklyn Dodger pitcher Don Newcombe to help other players with alcohol problems, and the leagues quietly faced up to the problem.

Professional football and basketball officials, however, were loath at the time to take action. Mr Cosell said many had the understandable attitude that professional sports is a business, and they didn't want to do anything that would affect the public attitude to the business.

The US National Football League has now taken steps to deal with the problems of chemical dependency among players, and some efforts are being made in the US National Basketball Association.

Mr Cosell said there is a growing understanding within sport itself that there is no shame in admitting to alcohol and drug abuse. At the same time, many players realize they cannot continue to live their high-flying lives and be alcohol- or drug-dependent.

If professional athletes want to adopt the posture of heroes they should speak out on television "not about beer, which I think is disgraceful for any athlete to participate in," but about the disease of chemical dependency and successful intervention and rehabilitation.

"As athletes continue to come forth, then and only then will the young people get to learn the truth and care about the men who have done what they have done, and come back."

Mr Cosell added: "I want to see the point reached in our society when America achieves a balance, when our educational structure is not being traduced at every level for the sake of winning games.

"I want to see the point where the educational structure has a proper concern from the very beginning to teach, to educate, to prepare our young people in matters such as chemical dependency."

Cosell: surrogate parents

Methadone maintenance 'a burden'

BC doctors want clinics re-opened

Incor Jowat

VANCOUVER — The British Columbia government has said it is willing to reconsider reopening its methadone maintenance clinics for heroin addicts.

The announcement followed the annual meeting in May of the province's doctors. A resolution was passed at the meeting reiterating a call for the reinstitution of the clinics.

The doctors said "the profession should not be expected to bear the brunt of treating (drug) abusers as has been true, due to government inadequacies, for the past four years."

The 15 or so methadone clinics in the province were closed in 1978 when the government decided to drop a controversial proposal requiring heroin addicts to receive compulsory treatment.

John Russell, executive director of the BC Alcohol and Drug Commission (now Alcohol and Drug Programs), said the commission has been reviewing the prospect of reopening the clinics for the past 18 months.

Ken Varnam, MD, chairman of the BC Medical Association's committee on drug dependency, said Mr Russell contacted the committee following the BCMA annual meeting and said he wanted to meet to discuss the subject.

Dr Varnam said currently most physicians have to refuse to treat addicts who come to them requesting treatment.

"The problem here is that because of the lack of government involvement in the treatment of drug abuse, doctors, especially doctors in the west end (of Vancouver) . . . have been swamped by drug addicts seeking prescription drugs," Dr Michael Scott, MD, said at the annual meeting.

Because of proposed changes in the federal Narcotic Control Act which would make physicians liable to trafficking charges even if they are legitimately treating patients for drug abuse, Dr Varnam said more pressure will be placed on addicts, and pharmacy hold-ups will become more common.

"If you increase your regulations without allowing an outlet for legal response to the regulations, then you just increase the pressure," he said.

Reinstituting the methadone maintenance clinics would also help treat the large number of drug addicts who stop using heroin in their mid-30s and become alcoholics, Dr Varnam maintains.

"If you have a controlled program, if you are watching what their health is doing and trying to counsel them . . . they're going to be less likely to have alcohol problems."

Dr Varnam gave an indication of the need for such a program.

He said that following the BCMA meeting one unnamed Vancouver physician who had worked for the alcohol and drug commission and had a methadone licence said he would start treating addicts again.

In the month following the meeting, Dr Varnam said, the doctor started 20 of his own patients on a methadone maintenance program, had 35 more patients referred to him, has 30 patients on a waiting list, and is receiving two or three phone calls a day from people requesting treatment.

However, there is some concern, voiced in one recent newspaper editorial, that BC's share of the addict population has dropped to 40% from 60% since 1978 and reinstituting the methadone program might attract addicts from other provinces.

Briefly...

One-drink drivers

TORONTO — More than a third of Canadians want drivers jailed after just one drink, says a recent Gallup poll. But 15 years ago a higher percentage favored such a law. Thirty-five per cent of the people surveyed this spring favored jailing even if the one drink doesn't put the driver over the legal limit for blood alcohol levels. In 1968, a Gallup poll reported 43% wanted such drivers jailed.

Harsher warnings?

WASHINGTON — Cigarette packages and advertising in the United States may soon carry a label which reads: "Warning! Cigarette smoking causes cancer, emphysema, heart disease; may complicate pregnancy, and is addictive." The proposed bill calling for the warning, approved by the Senate Labor and Human Resources Committee, also requires cigarette companies to provide the US Secretary of Health and Human Services with a complete list of each chemical additive and its quantity used in the manufacture of cigarettes.

Breakfast surprise

BATTLE CREEK, Mich — Ten-year-old Todd Harmeyer of Fort Wayne, Ind, got more than Frosted Mini-Wheats in his breakfast bowl one morning recently. In addition to the cereal, he poured out bits of burnt paper and what he thought were mouse droppings. The "droppings" turned out to be marijuana seeds. His mother has complained to the Kellogg Company here, which is investigating how the surprise got into the package.

Not enough addicts govt says

VANCOUVER — The British Columbia government is resisting reintroduction of methadone maintenance programs "because there aren't that many 'really addicted addicts anymore,' " says Carl Stroh, PhD, acting executive director of BC's Alcohol and Drug Programs (ADP).

Dr Stroh told The Journal the ministry of health is still considering a plea by the province's doctors to bring back methadone maintenance. However, the poor quality of heroin in the province, combined with the concern about addicting people to methadone, are considerations against its reintroduction.

He said the ADP does have clients on methadone in a "methadone stabilization program" which allows addicts to receive the drug on prescription "for extended periods of time without making a long-term commitment.

"The purpose of this is to help stablize their life situation and stabilize their use of drugs, including narcotics, and could be extended up to a year," he added.

"It's been sort of an interim measure, a way of providing services until there's a policy decision about the future of long-term methadone maintenance here.

"Our concern is that we don't want to addict people to narcotics who aren't severely addicted to narcotics when they come to us . . . We find very few people who are very addicted to a narcotic because of the very poor quality (of drugs sold illicitly), and because so many of the street users are using a variety of things."

The 15-or-so methadone maintenance clinics operated by the province were closed down in 1978 at the same time as BC decided not to go ahead with compulsory treatment for addicts.

And while the province is considering the BC Medical Association's (BCMA) plea for methadone maintenance clinics, there is "absolutely no consideration" of compulsory treatment, Dr Stroh said.

Ken Varnam, MD, chairman of the BCMA's drug dependency committee, told The Journal "there's no doubt that long-term methadone maintenance is necessary.

He said he is now treating 40 addicts on a daily basis as are other BC physicians, "but [redacted] of us would prefer not to have this load. We would be willing to halve our load because it would be more reasonable for the government to carry certain people. But they're still resisting even that aspect."

New act formalizes changes in BC alc/drug programs

(from page 1)

right to implement such a plan, but by then appeared to have lost its taste for it, and for the commission which had brought it so much bad press.

About two years ago — a year after the program started winding down — the commission was stripped of most of its power and given an advisory role with policy and administration flowing directly from the ministry. That process was virtually completed over the last year, said Mr Denhoff. The new act merely formalized the changes.

There will continue to be an advisory function, he added, but under the name of Alcohol and Drug Programs.

The program will provide the ministry of health with input from other ministries affected by alcohol and drug problems, such as the attorney general's office, he said.

Political weight of factors problematic

Public support a must in framing alcohol policy

By Behrouz Shahandeh

ZAGREB — A significant reduction in alcohol consumption and related problems can be achieved only with public input to policy and program development, says the chief of the Canadian government's health promotion directorate.

Ron Draper said here that, "results from policies and programs have been disappointing," because solutions neither acknowledge the problems of implementation, nor "address the constraints on significant change."

Furthermore, the political commitment required for such change usually does not exist, he told the 29th Institute on the Prevention and Treatment of Alcoholism.

The impact of prevention campaigns "at best is slow to appear, and results are marginal, if not equivocal.

"Information and education do not inevitably lead to behavior that fits the prevailing view of 'wise choice.' "

Thus, these efforts at prevention cannot offset the "basic social and cultural forces pushing in the direction of substance abuse," Mr Draper said.

He said he believes a "comprehensive alcohol policy" which combines taxation and limitations on marketing with prevention, help, and care, in an integrated manner, will "carry the force that individual interventions have lacked."

However, policy planners should question, "how much of it is realistically possible?"

Mr Draper said at least two preconditions are required for a comprehensive alcohol policy.

"One is an adequate level of widely-shared knowledge about alcohol problems and the impact and implication of various responses. The other is a high level of public support and political commitment to achieving a reduction in alcohol-associated problems."

He said governments must have access to policy options that "offer a reasonable prospect of success while falling within the boundaries of political acceptance, a dimension which itself varies from time to time."

Draper: a political act of faith

Political commitment, he added, can only be established by examining the reasons the public and the government may have for not wanting policies that will reduce alcohol use.

He pointed out that alcohol is a minority problem — 92% to 97% of people don't have alcohol problems.

It is also a social amenity which governments endeavor to make accessible to the public.

Its production is a source of jobs and capital formation, and it generates large tax revenues which, in turn, help to meet the rising costs of public services, he said.

"A comprehensive alcohol policy that includes regulatory and tax measures to reduce consumption will be seen by many as conflicting with these aims," Mr Draper said.

This conflict of goals is not unique to alcohol but the "relative political weight of the factors make it problematic." As the impact of such policies may not become apparent for a decade or more, "adoption of alcohol policies that are preventive is viewed as a great political act of faith."

He said any attempt at the adoption of a comprehensive alcohol policy requires the involvement of the public in its formulation and advocacy. He cited nuclear disarmament, women's issues, and minority rights as areas in which such citizen participation has emerged in recent years.

Two essential elements of a public participation strategy are: "open public access to information and deliberate recognition and support of the work of citizen groups."

Information should not only focus on the harm to the individual but also the social and commerical forces that shape the role of alcohol in daily life. Ownership of the alcohol industry, marketing strategies, and national and international trends in growth are essential elements of a policy of access to information, he said.

Mr Draper said the field of alcohol has been increasingly "professionalized" in the past 30 years, and this has resulted in a decline in the role of fraternal associations, churches, and temperance organizations as advocates and as care givers.

"Citizen involvement will require this trend to be reversed. Ideally the knowledge and insight of emerging professionalism should be combined with the skill and commitment of citizen action to strengthen the basis for change."

Mr Draper is the director general of the directorate, an arm of Health and Welfare Canada.

Tobacco curbs boosted at congress

WINNIPEG — In the next four years, more countries will take steps to control cigarette advertising and to limit levels of tar and nicotine in the cigarettes they produce.

However, it will be more difficult to introduce crop substitution in Third World countries that rely increasingly on income from tobacco, predicts Kurt Baumgartner, secretary general of the Fifth World Congress on Smoking and Health held here in July.

The sixth world meeting will be held four years from now. At the fifth, said Mr Baumgartner, the increase in smoking in developing countries was "the most important issue" and pervaded the conference.

He said that's because the tobacco industry has increased its efforts to improve sales in the Third World, and also because tobacco is a valuable cash crop in those countries, providing jobs and economic security. And that exacerbates the problem, Mr Baumgartner, executive director of the Canadian Council on Smoking and Health, told **The Journal**.

The developing nations are "the last frontier" for the industry because sales have either declined or levelled off in developed countries in recent years, he said.

The minister of health for Swaziland told the conference the Third World is being "exploited" by the tobacco manufacturing industry that serves the interests of an affluent group in the developed world.

Samuel Hynd, MD, said tobacco is a "slow, sinister, suicidal drug" that could create problems in developing countries long after the problems are reduced in the developed world.

"How do you expect us to reach the World Health Organization (WHO) goal of 'Health for all by the year 2000' when we carry the heavy burdens of poverty, ignorance, and disease, only to be exploited by those of the affluent and educated who have the expertise to stop all of this self-destruction?" he asked.

He said the developing nations are faced with the dilemma that they must battle the very strong and organized tobacco industry with few resources.

"It is a horrifying thought that when we are still struggling hard to overcome all the health hazards of communicable, diarrheal, respiratory, nutritional, and parasitic diseases that plague our communities, we are now to contend with the export of diseases from the developed, industrialized nations."

Delegates to the conference shared ideas and techniques for battling the tobacco industries' efforts at promoting smoking in the Third World.

About 100 of the 900 delegates were from the Third World. Mr Baumgartner said they would make important contacts with their counterparts from around the world which may prove valuable in fighting the rise of smoking in the future.

Judge not the city cyclist too harshly

By Wayne Howell

A cyclist in a city has to be aware of a great many things if he wants to stay alive. He has to watch out for storm sewer grates that can suck in his front tire; he has to watch out for people sitting at the wheel of parked cars, who can (a) suddenly pull out in front of him, or (b) whip open their doors unexpectedly, causing him to come to a quick bone-crunching halt; he has to watch out for buses that will cut him off; and he has to watch out for motorists who will make a right turn in front of him with no regard for his right of way.

As a city cyclist with 10 years experience, I have had to deal with all of these threats, and the fact that I am sitting here writing about them, rather than making unintelligible sounds on a neurological ward, indicates that I have managed to deal with them successfully. But that is not to say I haven't had my share of close calls. Curiously enough, a significant number of them have occurred not because of drunk drivers, but because of drunk pedestrians.

I first encountered this unexpected problem in the summer of 1977 when I stopped at a light, and a woman standing on the sidewalk approached me and asked me for the time. Before I could comply with her request, she fell upon me. She did not weigh more than 100 lbs, but it is difficult to deal with a 100-lb weight when one is straddling a 10-speed and not expecting to be so accosted.

We staggered sideways in a most peculiar ballet and came to rest with a thud against a red Volvo which, fortunately for both of us, was stopped, as was I, waiting for the light to change. The woman careened off me like a billiard ball hitting a cushion (she never did get the time) and lurched down the street. I rebounded somewhat unsteadily from the Volvo, the owner of which was engaged in two things simultaneously; he was trying to extricate himself from his seatbelt, without interrupting the flow of colorful obscenities he was casting in my direction. To his credit, he accomplished the first task in short order, while managing to give a very good account of himself in the obscenity department, improvising cleverly on several well-known themes.

Hell hath no fury, they say, like a woman scorned. But I doubt the author of that aphorism ever faced an enraged Volvo owner who believes his lovingly-laquered paint job has been scratched by a cyclist. Fortunately, the light turned green, and either because of my stupid apologetic smile, or because of some private urgency, he hopped back into the car and sped off.

Two years later I had my first moving encounter with a drunk pedestrian. He was drifting across the street like a schooner under full sail. I was feeling somewhat testy because of an altercation with a bus driver who had cut me off, and I was in no mood to yield to jaywalking pedestrians: I was going to exercise my rights under the Highway Traffic Act and demand my right of way. And since it was 8:30 in the morning, it had not occurred to me that the jaywalker was walking on cloud nine. Stubbornly, I continued on my tack, and he continued on his.

Eventually, however, it became apparent to me that discretion has its virtues, notwithstanding the satisfying feeling one gets when one exercises one's two-wheeled rights in a world of four-wheelers, and so at the last moment I made a quick correction. It would have sufficed to avoid a collision I am sure, had not his unsteady legs chosen at that moment to make an imperfect step which brought us in closer proximity than either of us cared for. I missed him with the wheel, but got him with the handlebar; luckily my momentum, and the glancing nature of the contact, did not result in any grave damage to either of us.

My next encounter with intoxicated pedestrians occurred just recently.

Once again, I had stopped for a red light and I was straddling the crossbar. This time I was approached by a most peculiar trio. Two young men of rather loutish demeanor and a barefooted young woman wearing a gypsy dress left over from a second-rate production of Carmen advanced on me, arm in arm in arm, as if they were playing some version of the old children's game Red Rover Come Over, and I was "it."

(In his syndicated newspaper column Allen Fotheringham is always complaining that Ottawa is the dullest city in Canada, if not the world. Were he to encounter this senorita and her swains he would undoubtedly think differently.)

They say that your whole life flashes before your eyes the moment before you die. I don't know about that, but I do know that when the one fellow crashed into the back wheel of my bicycle and turned to punish me for so thoughtlessly getting in his way, everything seemed to happen in slow motion. As he prepared to deliver the blow, I was obsessed not with trying to place my feet on the pedals and, to use the vernacular, getting the hell out of there, but with a tattoo on his right biceps which swelled and rippled in quite spectacular fashion as the muscles tensed beneath it. Fortunately, the first missed, and I made good my escape. There is only one good thing to be said about inebriated louts: their aim is not too good.

Being of a scientific bent, I am naturally eager to make some correlations regarding my experiences with inebriated pedestrians. The only correlation I can come up with is this: all three incidents took place within a few blocks of the bus terminal. I leave it to better minds than mine to figure out the significance of this. I only want to leave you with this thought: bicycle riders are notorious for running red lights and it is something that infuriates motorists to no end. Do not judge us too harshly; we cyclists face hazards that you motorists know not of.

NEWS

RESEARCH UPDATE

Coffee boosts cholesterol levels

A Norwegian study has shown coffee is a major contributor to the variation in levels of total cholesterol. The study by researchers from the Institute of Community Medicine at the University of Tromosø examined the relationship between coffee consumption and levels of serum total cholesterol, high-density lipoprotein (HDL) cholesterol, and triglycerides. Subjects were 14,667 people from the Tromosø region of Norway aged 20 to 54 years. From the lowest to highest coffee-consumption category, the mean serum cholesterol level was found to increase by 14%, and the mean serum tryglyceride level increased by 10% in men and 20% in women. The researchers said the association is strong and consistent; "its magnitude makes coffee one of the strongest determinants of serum cholesterol levels in the present population." They said while evidence about the relation between coffee consumption and coronary heart disease is contradictory, the magnitude of the cholesterol-raising effect of coffee, which suggests at least a two-fold increase in the risk of coronary heart disease, warrants further investigation.

New England Journal of Medicine, July 16, 1983, v.308:1454-1457

Gout patients do drink more

Heavy alcohol consumption, more than any other element of diet, is characteristic of many people with gout, suggests a study at Guy's Hospital in London. The finding, which supports a widely accepted notion, resulted from a study of the dietary habits of 61 men with gout and 52 control subjects. Researchers from the departments of rheumatology, medicine, and dietetics said the only striking difference between the two groups was that "gouty patients drank significantly more than controls." Beer was most popular among these patients, and 41% of those with gout consumed more than 2.5 litres of beer a day. The study said it can be reasonably assumed that the high alcohol content of many of the gouty patients' diets contributed in a large measure to their hyperuricemia — an excess of uric acid in the blood characteristic of gout.

Annals of the Rheumatic Diseases, 1983, v.42:123-127

FAS going undetected

Fetal alcohol syndrome (FAS) is not being correctly diagnosed by a number of Australian doctors, a study from that country indicates. A survey of 20 patients with FAS seen at the Royal Alexandra Hospital for Children in Sydney found that in only nine of the mothers was alcohol abuse recognized and associated with their babies' anomalies in the first months after birth. In some cases, the diagnosis of FAS was delayed for several years. Researchers Anthony Lipson, David Walsh, and William Webster said an appreciation of the effects of alcohol abuse in pregnancy can often be delayed when attention is directed solely to a malformation, growth disorder, or central nervous system dysfunction in the infant. "Recognition is important because of the need of a family with an alcohol problem for special help to identify the child at risk in order to faciliate identification of associated medical and educational problems, and, if abuse continues, to try and prevent further pregnancies," the report concluded.

The Medical Journal of Australia, March 19, 1983, v.1:266-269

IV alcohol for acute asthma?

A British study has shown that alcohol given intravenously can provide relief for asthma patients. Jon Ayres and T.J.H. Clark from the department of thoracic medicine at Guy's Hospital, London, showed that in five asthma patients an intravenous infusion of 250ml of saline and 8% ethanol improved specific airways conductance and acted as a bronchodilator, but is less potent than salbutamol. The study noted a greater bronchodilatation might have been achieved if higher concentrations of ethanol had been used. The researchers said the mechanism of the ethanol-induced effects is unclear. While alcohol given orally has been shown to improve asthma symptoms, alcoholic drinks are better known for making asthma worse and, they said, "it would be folly to encourage patients to self-treat worsening asthma with alcohol." However, the study findings suggest "there may be a role for the use of intravenous ethanol in acute asthma refractory to conventional bronchodilators."

Clinical Science, 1983, v.64:555-557

Collagen and smokers

Significantly higher levels of collagen have been found in the atherosclerotic arteries of smokers undergoing coronary artery bypass graft operations. A study of 52 consecutive patients with two- or three-vessel disease admitted to Hammersmith Hospital, 38 of whom were smokers, found that the collagen content in both artery and aortic samples was higher in smokers than in non-smokers, and the cholesterol content in the aorta of smokers was also higher. The research group said cigarette smoking might increase the cholesterol content of the arterial wall and secondarily increase its collagen content by increasing the number of lesions per blood vessel. The group concluded that while the observations shed no light on the development of atherosclerosis, the findings indicate "different risk factors may promote atherosclerosis in different ways."

Lancet, May 14, 1983, no.8333:1070-1073

Pat Rich

Few alcoholics, addicts suit liver transplant, say experts

WASHINGTON — Most alcoholics and drug addicts are not suitable candidates for liver transplants, an expert committee has advised the United States government.

The three-day conference of experts gathered together by the National Institutes of Health recommended in a final report that liver transplants no longer be considered experimental but therapeutic.

Reclassifying liver transplants would put them in line with kidney and corneal transplants as routine medical procedures and eligible for payment under private and government health insurance plans. A liver transplant in the US costs approximately $100,000.

The experts noted that at least 50% of the cases of cirrhosis in the US are attributable to alcohol abuse, and alcohol abuse is the leading cause of hepatic morbidity and mortality. In addition, many drug abusers contract chronic hepatitis.

They said a liver transplant could be considered for an alcoholic who develops evidence of progressive liver failure, despite all available medical treatment, and who has proven he or she has been abstinent for a lengthy period.

But, their report said, "only a small proportion of alcoholic patients with liver disease would be expected to meet these rigorous criteria."

They based their conclusion that "liver transplantation is a therapeutic modality for end-stage liver disease that deserves broader application" mainly on data they studied from four university transplant centres: Pittsburgh (US); Cambridge (England); Hanover (Germany); and Groningen (The Netherlands).

The recommendations are expected to have a major influence on US public health officials who will decide shortly whether to reclassify liver transplants and place them in the therapeutic category. Survival rates for all organ transplants have risen dramatically in the past three years with the use of the immunosuppressive drug cyclosporin A.

Pressure/drug interactions unpredictable

Drugs hold hazards for divers

By John Ingalsbe

TORONTO — Scuba divers who use alcohol or other drugs before entering the water could be endangering their lives, a University of Western Ontario (UWO) researcher says.

Richard Philp, PhD, chairman of UWO's department of pharmacology and toxicology and also an experienced diver, has been using laboratory animals to study the effects of gases under pressure when combined with alcohol and other drugs. He has found that the pharmacology of certain substances can be changed under pressure.

"It has always been axiomatic that divers shouldn't drink before diving," Dr Philp told **The Journal**, "but what is new is that the interaction of pressure with all kinds of drugs can cause unpredictable reactions."

His research, which began six years ago, was prompted by concern about the social use of drugs like alcohol and marijuana by sports divers, and also the use of prescription and over-the-counter drugs — decongestants and motion sickness drugs, for instance — by both sports and commercial divers.

"Our major concern is that the judgement (of divers taking drugs) may be sufficiently impaired that they can't make crucial decisions. What we've found is that the effects of anything which impairs judgement might be exaggerated under water."

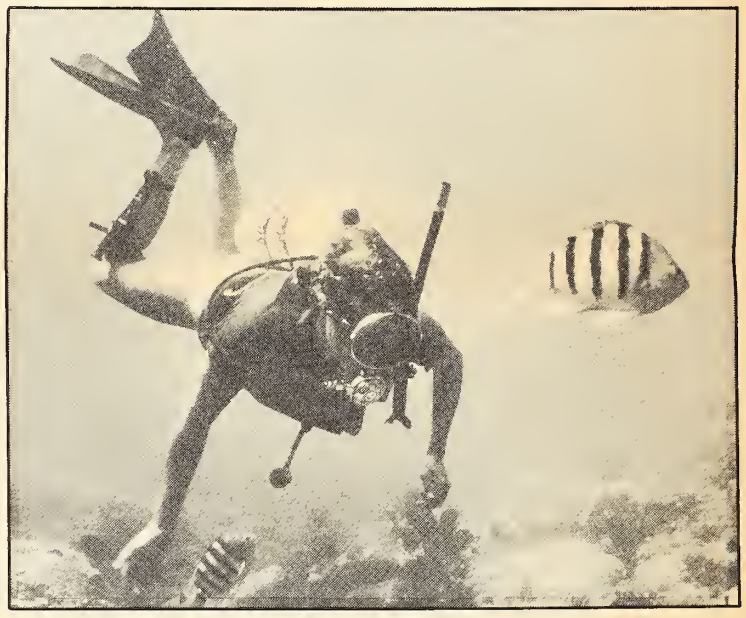
Compressed air (from a diving tank) itself can cause loss of consciousness at lower depths, Dr Philp explains, but when drugs or alcohol are taken there may be a danger — slower reaction time, poor judgement, or even loss of consciousness — at much shallower levels.

He admits there is still much to learn about just how substances are altered under pressure. Certain drugs or combinations of drugs can trigger complex reactions in the brain, depending on what drugs are used, the dosage, the amount of pressure, the time under water, and even the temperature of the water (cooler water can increase the sedative effect of a drug).

The potential danger of alcohol or drugs may be greatest for commercial divers, Dr Philp says, because they are often engaged in strenuous physical activity. Some commercial divers live in a pressurized atmosphere for days or even weeks, and they may routinely take medication.

Dr Philp recommends divers not drink alcohol before diving. Even one drink could have an effect on how an experienced diver handles himself in an emergency.

"It's probably wise not to go diving even with a hangover," he says. "And if a diver isn't sure about how other types of drugs will affect him, he should consult a doctor," preferably an expert in diving medicine, he says.



Divers: impaired judgement may impede decision making

Available hypnotics failing to meet therapeutic ideal for the chronic insomniac

By Incor Jowat

KELOWNA, BC — Drugs marketed as hypnotics fall far short of the ideal for treating insomnia.

Jonathan Fleming, MD, director of psychiatric in-patient services at Shaughnessy Hospital in Vancouver, said of the 6% of the adult population who complain of insomnia to a physician, half will receive an hypnotic.

Dr Fleming told a recent meeting of the British Columbia Medical Association that the use of hypnotics in Canada has declined after peaking in 1971.

He warned "it's not sufficient to take a complaint of insomnia at face value," and said doctors must look carefully at the patient's sleep history.

"It would be inappropriate to start using hypnotic medications unless there are significant daytime consequences (of the insomnia).

"If we're going to define an ideal hypnotic, it would be effective on the first night, it would not disrupt sleep architecture . . . it would obviously increase the total sleep time, and it would be effective for the duration of the treatment prescribed. And lastly, it would not produce adverse side effects or a withdrawal syndrome.

"The available hypnotics fall far short of any ideal," Dr Fleming added.

"The drugs that are marketed as hypnotics really reflect marketing practices rather than psychopharmacology."

Dr Fleming recommended that if a doctor is going to prescribe an hypnotic at all, it should be an ordinary benzodiazepine like oxazepam.

Doctors should avoid first-contact prescribing, he said, because patients should be made aware "there does not seem to be any immediate help that is available for the chronic insomniac."

He also advised doctors to monitor patients for dosage escalation and daytime residual effects from the drugs.

DuPont wants hard, clear anti-drug messages...

By Terri Etherington

TORONTO — Drug education programs should focus on the process and immediate consequences of dependence rather than on long-term health risks, says Robert DuPont, MD.

"What is utterly missing . . . from most of our education is the process of dependence as a vulnerability itself," says Dr DuPont, president of the American Council on Drug Education, and former director of the United States National Institute on Drug Abuse.

"Chemical dependence or drug dependence is not casual, it's not a fad, it's not like blue jeans. Drug habits tend to be for a lifetime and are not something easily acquired and then discarded," he told the conference Cannabis: Consequences for Canadians here.

"We've got to understand that drugs work," Dr DuPont said, and that the behavior changes are powerfully reinforced by social, economic, historical, and cultural factors.

He praised the Canadian health and welfare booklet *Stay Real* (**The Journal**, June), as "an example of the truly-brilliant messages about the health risks associated with marijuana use."

However, he also criticized Stay Real and other drug education programs for making a distinction between physical and psychological dependence. "Of all the unhealthful distinctions in the drug field, that has got to be the most unhealthful.

"The issue is not whether it's a psychological dependence or a physical dependence, it is the extent of the dependence. When we've got 20 million regular cannabis users in the US — four million of them (age) 17 and younger — you know there is a serious problem."

Dr DuPont said consequences of drug use are perceived as being delayed and uncertain. "The individual doesn't know whether he himself is going to get lung cancer, have an automobile accident, drop out of school, get arrested, or whatever else."

DuPont: unhealthful distinctions

"We've got to bring the consequences closer."

The best place to make the consequences more immediate and real is in the family, he added. "But the family has to be informed and the family has to be tough to make this work."

Dr DuPont credits the parents' anti-drug movement as the single, most-important factor in the apparent decline in drug use by teens (**The Journal**, Apr).

He urged parents and educators to make it plain that any drug use is unacceptable. "I favor any policy that gets that message across in an unambiguous way."

The message should not be, " 'we don't want you drunk' but, 'we don't want you drinking,' " he said.

On control of drug use in schools: "we make a terrible mistake by trying to exclude the police." He said he would not hesitate to make arrests, search lockers, and even let parents know there is a urine test for cannabis.

Dr DuPont said there should be social rejection of drug use and reward for the majority of students who are not using drugs.

"Anything else, in my view, shows that you are not really serious about what you are doing."

...science muddles process, he says

TORONTO — The ambiguities of the scientific standard of proof may be an obstacle to definite anti-drug messages, says Robert DuPont, MD.

Dr DuPont, president of the American Council for Drug Education, said scientific standards of proof always have question marks, and "all the 'mays' and the 'possibles' and the 'coulds' give a tremendous opening to run this (drug) epidemic through and keep it going."

However, Harold Kalant, PhD, assistant research director and head of biobehavioral studies at Ontario's Addiction Research Foundation here, said it is important not to confuse the purpose of scientific standards of proof.

Dr Kalant was part of a five-member panel questioning Dr DuPont following his address here at the Cannabis: Consequences for Canadians conference.

Dr DuPont commented that the question of health risks of cannabis and other drugs has been fundamental to the problem of educating against drug use, but complained that the scientific standard of proof is "a standard that says we really don't know."

Dr DuPont: "We've got a study that says this and a study that says that. Or we've got a study that says this for rats but we don't know for people. Or we've got a study that shows it in this particular situation but we don't know what the effect is in combination with other drugs.

Kalant

"The problem is when that gets brought into education and public policy it gets read as 'we don't know,' 'it doesn't do any harm,' or whatever else, and that is the tragedy of this health area."

A line has to be drawn somewhere on the basis of risk, he said.

However, Dr Kalant in the question and answer period countered, "I don't think there is any conflict between the use of scientific standards of proof and common sense as applied to personal life and public policy.

"The real objection is to people who pervert scientific proof to support an essentially dogmatic, ideological, or other stance — twisting the evidence to suit the stance rather than using the scientific proof for knowing what the starting points are before they begin making judgements."

GILBERT

'. . . we are only just beginning to understand the mechanism of action of caffeine, the world's most popular drug, and of coffee, the world's most popular beverage . . .'

Coffee and opiates

By Richard Gilbert

Caffeine and coffee continue to feature in both the scientific and the secular news. For example, in January this year one issue of *Nature* — the "International Weekly Journal of Science" — contained two brief articles on caffeine or coffee. One of these was the subject of an opinion piece in the same issue. The same week, the Toronto *Globe & Mail* carried a news item headed "Less toxic than salt, caffeine: biologist defends pesticides." A few weeks later another Globe headline read "Some heart flutters linked to caffeine."

One of the Nature articles added technical fuel to the very open controversy concerning the possible ill-effects of caffeine on heart disease. It was entitled "Caffeine induces a transient inward current in cultured cardiac cells." Its author, William T. Clusin of Stanford University Medical School in California, reported adding a concentrated caffeine solution to "spontaneously beating spheroidal aggregates" of cultured cells from the hearts of chick embryos, and finding an effect "having similar features to that of digitalis toxicity." (Caffeine, true to form, has also been reported to abolish digitalis-induced arrythmias.)

The other Nature article had the title "Coffee contains potent opiate receptor binding activity." Its authors were J. H. Boublik and five others from various Australian institutions. They reported that "instant coffee powders from a variety of manufacturers compete with tritiated naloxone for binding to opiate receptors in . . . rat brain membrane preparations, with no significant difference between normal and decaffeinated coffee."

Antagonist

The next question was whether this substance that binds to opiate receptors does so in a manner like morphine, with its profound effects on mood, physiology, and behavior, or in a manner like the morphine antagonist naloxone, whose action is generally evident only when an opiate is being administered. The researchers found that the substance (or substances) had an antagonistic effect in that it reduced morphine-caused inhibition of electrically-induced twitches in guinea pig gut.

What this means is that there is something in coffee other than caffeine that can block the action of morphine, heroin, and other opiates, at least when examined in the pharmacology lab. The experimenters also tested instant tea, cocoa, soup powders and stock cubes, extracts of yogurt and cream cheese, and caffeine, theophylline, and theobromine. All of these were without activity at morphine receptors.

The authors noted a 1982 report to the effect that caffeine, if anything, appears to have the opposite kind of effect — it may stimulate the release of endogenous morphine-like substances, and such stimulation may be partly responsible for the popularity of caffeine-containing beverages. Thus there may be a real puzzle here. Coffee contains caffeine, which may cause an opiate-like effect, and also an unknown substance that blocks the action of opiates.

Jogging-caused analgesia

The possibilities are complicated by evidence that low doses of an opiate antagonist may sustain or enhance an analgesic effect. For example, in 1981 Richard Haier and two colleagues reported a study of analgesia induced by jogging. A 2-mg dose of naloxone increased analgesia after jogging — subjects supported a weight on their index fingers for longer before reporting pain — whereas a 10-mg dose completely blocked the analgesia that jogging had produced. Their data are consistent with earlier work.

According to Boublik and colleagues, a cup of coffee contains the equivalent of about one-third of an ampoule of naloxone, ie, much less than one milligram. Thus it is possible that the opiate antagonist(s) present in coffee may act in a morphine-like manner and produce the desirable mood and other changes associated with morphine use.

Puzzles remain from earlier work on caffeine and opiates. Caffeine has been found to potentiate the analgesic effect of morphine, but it has also been found to accentuate withdrawal signs in rats that are already opiate-dependent — an apparent antagonist effect.

Thus coffee would seem to contain two or more substances, caffeine and at least one other, that have actions in relation to opiate-receptor activity. Unravelling the precise relationships in each case — agonist or antagonist on the one hand, and acting through endogenous or exogenous opiates on the other — will take a great deal of careful work.

The opinion piece on the topic in Nature that week was by Leslie Iverson, director of the Neuropharmacology Unit at the Medical Research Council Centre in Cambridge, England. Dr Iverson speculated as to how the coffee drinker might be affected by all this potential opiate-receptor activity, noting at the outset the possibility that the active substance(s) detected by Boublik and co-workers may have no effect. "It is possible that the active substance is not absorbed or is readily metabolized," wrote Iverson, "and thus never gains access to the nervous system."

Unwitting exposure

Iverson continued: "On the other hand, opiate antagonists such as naloxone have few if any detectable effects in normal subjects. When given in a blind manner, normal subjects are unable to determine whether they have received naloxone or placebo. It is thus possible that coffee drinkers are unwittingly exposed to opiate receptor blockade, although it is not clear how this may contribute to the overall effect. It remains more likely that the stimulant actions of coffee do result from the substantial amounts of caffeine consumed — about 100 mg per cup."

Iverson went on to argue for a particular theory of caffeine's stimulatory activity, one that focuses on the ability of caffeine to antagonize the effects of adenosine on a variety of tissues. Adenosine, like caffeine, is one of the class of compounds known as purines. When administered to animals, adenosine has a variety of effects on the cardiovascular and nervous systems. A form of adenosine is a potent behavioral depressant. Evidence points to the existence of specific adenosine receptors in brain membranes and to the possibility that endogenous adenosine may act as a circulating hormone.

My own hunch is that although caffeine is undoubtedly the most important psychoactive substance in coffee (with adenosine receptor inhibition being a likely mechanism of action), the possible involvement of opiate receptor activity should be pursued vigorously. It has often occurred to me that decaffeinated coffee gives drinkers more of a lift than might be expected from the taste alone, or from association with former use of regular coffee. To discover that this lift is of the kind produced by opiates such as morphine, but perhaps produced endogenously in the form of endorphins, would indeed be exciting.

It is clear that we are only just beginning to understand the mechanism of action of caffeine, the world's most popular drug, and of coffee, the world's most popular beverage. Research on caffeine has been dismissed in the past as being irrelevant to an understanding of the action of and problems posed by "real" drugs. Current research activity in this area may prove to be at least as exciting and productive as research into alcohol and tobacco.

NEWS

Avoiding sex may threaten recovering alcoholic women

WASHINGTON — Unresolved sexual issues can be a major threat to the recovering alcoholic woman during the early months of sobriety.

Mickey Apter-Marsh, PhD, of the Institute for Advanced Study of Human Sexuality, San Francisco, said findings in a study of 61 recovering alcoholic women run counter to accepted wisdom.

Because of the interrelationship between sex and alcohol, women in early sobriety are frequently advised by alcoholism counsellors and AA (Alcoholics Anonymous) members to refrain from sex.

"Censuring sex is not the answer, and may in fact be a greater threat than an asset in maintaining sobriety," Dr Apter-Marsh told a session on sex and drugs at the 6th World Congress on Sexology here.

"Being sexual is not the problem, the problem is more in how to express sexuality either alone, or with a partner, without the aid of alcohol and for the appropriate reasons."

Dr Apter-Marsh said the study, done in conjunction with the Haight-Ashbury Free Medical Clinic, San Francisco, (see Alcohol/cocaine below) was among 61 white, heterosexual, middle-class, well-educated women. Their mean age was 40, and mean sobriety 4.2 years, although none was interviewed with less than a year's sobriety. Half of the women had consistent sexual partners.

Harvey McConnell reports from the 6th World Congress on Sexology

Dr Apter-Marsh said they found that while the women had their highest frequency of sexual activity with their partner during the addiction to alcohol, their ability to reach orgasm was much less.

"When the ratio of the level of orgasm to the level of behavior is considered, they were, in fact, more orgasmic in sobriety," she added.

Prior to becoming alcoholic, the women reported orgasm about 36% of the time. In extended sobriety, they attained orgasm approximately 70% of the time. Frequency of orgasm from masturbation, about 85% of the time, was similar before, during, and after alcohol addiction.

The study showed 80% of the women felt that drinking alcohol improved their sexual functioning, but not the quality of their orgasms. However, with sobriety, only 5% of the women continued to believe that alcohol had improved their ability to function and the quality of their orgasms.

Dr Apter-Marsh said that in the first three months of sobriety, sexuality in women undergoes considerable change, and many are frightened by sexual stirrings for the first time in an un-inebriated state. They need to be reassured about fears and anxieties about their sexual selves.

Early sobriety sets the stage for the women to regain their respect, dignity, and sexual satisfaction, and this relates to a positive sexual self-image.

Dr Apter-Marsh: "Thus, sexuality itself needs to be addressed in early alcoholism treatment. If it is ignored, it leaves many questions unanswered, many painful memories unresolved, promotes unnecessary sexual concerns, and delays the construction of the foundations of alcohol rehabilitation, self-worth, and self-esteem.

"It is becoming more obvious that unresolved sexuality issues can be a major threat to the recovering alcoholic woman."

She added that the study found "orgasmic ability reaches its zenith in the later stages of sobriety. Sexuality undergoes recovery."

Alcohol/cocaine effect on sex varies: study

WASHINGTON — Alcohol and cocaine are used together by many men and women to try to enhance their sex lives, but the results vary considerably.

David Smith, MD, medical director of the Haight-Ashbury Free Medical Clinic, San Francisco, reported the results of a study of 159 men and women entering a substance abuse and sexual concerns project to the 6th World Congress on Sexology here.

Researchers found 64% of the men said alcohol improved their sexual functioning, 33% said alcohol impaired their sexual functioning, and 3% said it had no effect.

Among the women, 65% said alcohol improved sexual function, 30% said it impaired it, and 5% said it had no effect.

Among those who used cocaine and alcohol, 65% of the men said cocaine helped with orgasm, and 35% said it impaired their ejaculatory ability. In contrast, 20% of the women said cocaine enhanced their sexual desire and orgasmic ability, and 80% felt cocaine made sex worse.

Many of the men and women said a cocaine-alcohol combination allowed them to engage in marathon bouts of sexual intercourse.

Dr Smith said that as men and women became addicted to psychoactive drugs sexual dysfunction became dominant. On the other hand, in early detoxification, many feared that without the use of psychoactive drugs they would not be able to establish a realistic sexual relationship.

"This link must be disrupted during recovery as any use of a psychoactive drug may trigger a serious relapse back to the primary disease," Dr Smith added.

Sex therapists often ignore dependency

Drug use can be factor in intimacy problems

WASHINGTON — Many therapists try to treat sexual or relationship problems in couples without ever considering the question of chemical dependency.

Eli Coleman, PhD, professor of human sexuality at the University of Minnesota, Minneapolis, said many couples appear with sexual relationship problems "and we don't even ask about their chemical use or dependency, or take a history. We go on blindly trying to treat sexual and intimacy disorders."

On the other hand, if a couple, or one member, is chemically dependent and has an intimacy problem, treatment through AA (Alcoholics Anonymous) or Al-Anon is not enough.

"They really have intimacy disorders that need professional care," he added.

Control over their drinking or drug use must be maintained while they are helped to regain their intimacy.

Dr Coleman told the 6th World Congress on Sexology here that a six-month study of 300 patients at the university found almost 25% were chemically dependent and another 17% came from a family with a history of chemical dependency.

Both chemically-dependent men and women said their sexual desire was inhibited, and they had problems with their relationships.

Dr Coleman observed: "I don't say alcoholism or chemical dependency created all these problems. Many of these individuals had intimacy and sexual disorders which were systemic and would have existed without the chemical dependency."

Joel Spike, DO, a therapist from Miami, Fla, said that when he treats couples with a chemical dependency problem he points out they are in a love triangle "and the first thing they must try to do is get out of that triangle by removing the drug."

The prime job of the therapist is to "improve peoples' attitudes, to get them out of the immediate gratification they are getting from drugs, to develop in personal relationships, and to try and enjoy themselves sexually and otherwise."

Study finds 'alarming' drinking, smoking rate

TORONTO — An "alarming" 48% of 18- to 19-year-old Canadian males drink alcohol on a regular basis (one to three times a week), says a survey of Canadian fitness and lifestyle.

The survey shows a similar proportion of females in the same age group admit to being regular smokers.

And Senator Ray Perrault, minister of state for fitness and amateur sport, suspects these figures may be low because "young people may have been overly modest in reporting actual smoking and drinking habits."

The survey, the largest and most comprehensive study of fitness and lifestyle in the world, also shows that children and youth are more physically active than the rest of the Canadian population.

However, "I find it rather distressing to see young people beginning to smoke when they should be at the height of good health and well-being," Senator Perrault said in a press statement.

More than 22,000 Canadians were interviewed and some 16,000 completed fitness tests in the 1981 survey. The figures may be low in the case of smoking and drinking habits because respondents were questioned in their homes in the presence of other family members, Senator Perrault added.

The survey shows that 3% of males and 6% of females aged 14 to 15 years admit to regular alcohol consumption. By the time they are 16 and 17, 24% of males and 19% of females drink regularly, the survey says.

Smoking is more prevalent among females than males in every age group. Among 14- and 15-year-olds, 11% of males and 17% of females say they smoke. In the 18 to 19 age group, 27% of males smoke compared to 46% of females.

The survey was discussed here at the 50th annual conference of the Canadian Association for Health, Physical Education and Recreation.

Alcohol revenues in US may go to Medicare

WASHINGTON — Federal alcohol and tobacco tax revenues could in future be earmarked for the United States program for the elderly to help cover expected deficits in the next decade.

The proposal to earmark the taxes, which currently bring in $11 billion a year, is under consideration by a special advisory council of outside experts set up by the department of health and human services to look at ways to raise further revenue for Medicare.

At present, the Medicare program is financed mainly from Social Security taxes and is in the black. But gradual aging of the US population and uncontrolled medical costs indicate the program may face a $200 billion to $400 billion deficit by 1995.

A study for the expert group by the National Center for Health Statistics said alcohol- and tobacco-related illnesses are responsible for a major proportion of the costs of the Medicare and Medicaid (for the poor) programs financed largely by the US government.

The centre said that in 1980, some $4 billion a year was paid out to treat patients with smoking-related diseases. Medical costs for alcohol-related diseases are high as well, although the amount is harder to pinpoint.

NEWS

OMA identifies specific groups at risk

Doctors urged to warn of cannabis hazards

By Betty Lou Lee

TORONTO — Ontario doctors are being urged to question their patients about cannabis use and counsel them about possible adverse effects among specific groups and in certain disease states.

These include men and women who wish to become parents, and respiratory, epileptic, and cardiovascular patients.

The Ontario Medical Association (OMA) at its annual meeting here adopted a study by its committee on public health that attempted to identify those for whom information about cannabis is particularly important.

Research findings the committee considered pertinent to various groups included:

• Pregnant women: "Cannabinol [tetrahydrocannabinol (THC)] crosses the placenta and becomes a potential teratogen. To date, no strong trend to a single defect has arisen but subtle developmental defects are being observed now, especially of the central nervous system, along with evidence of decreased size and weight of infants at term."

• Women who plan to be mothers: Strong evidence from *in vitro* exposure of cells to THC, and *in vivo* studies of animals and humans, demonstrate "abnormal cell proliferation and DNA content. Cells with fewer than 30 chromosomes are common occurrences. It is not known what implications this has on germ cell change, risk of abnormalities in offspring, or possible future disease states."

• Men who plan to be fathers: "Decreased weight of the prostate, seminal vesicles, and testes in men who are light and heavy users have been demonstrated." (The committee defined light use as one or fewer exposures per week, heavy as more than two.) Sperm number and motility are decreased in heavy users, but this is "generally reversed after one month of complete withdrawal from cannabis use."

• Respiratory patients: "There is convincing evidence of increased obstruction in the large and small airways, which incompletely reverses after withdrawal, suggesting long-term effects." Chronic inflammatory changes, and decreased effectiveness of macrophages (protective cells in the lungs) are seen. Carcinogens in cannabis smoke are similar to those in tobacco, and there may be 50% more of them.

• Epileptics: Even small amounts of cannabis reduce the neurotransmitter acetylcholine in the central nervous system. "Also, because many psychotropic drugs modify metabolism of neurotransmitters, a wide variety of interactions with cannabis seems possible. Studies investigating psychotropic drugs and cannabis interaction, however, are lacking."

• Cardiovascular patients: Cannabis increases the work of the heart, "elevating blood pressure in some individuals," so those with hypertension, cerebro-vascular disease, arrythmias, and coronary heart disease "would be expected to have increased risk from cannabis."

The OMA will prepare an information sheet with these data to be sent to all physicians.

It also adopted a committee recommendation "that funding and research groups be made aware of the urgency of acquiring and disseminating information on the medical implications of cannabis in different age groups, and drug interactions."

The OMA policy on cannabis continues to be that there should be no change in legislation that will encourage its use.

AMA getting stricter on methaqualone use

By Charles-Gene McDaniel

CHICAGO — The American Medical Association (AMA) is advising physicians to avoid prescribing methaqualone as a sedative because of the high potential for abuse and development of physical dependence to the drug.

The policy, adopted in June, recommends that, when necessary, physicians prescribe other treatments, including hypnotics of equal or greater efficacy.

The only exception to the recommendation is for patients with porphyria, a complex blood disorder, for which methaqualone is one of several drugs that may be indicated.

The AMA council on scientific affairs prepared the report after the New York State Commission on Drug Abuse requested an opinion on the restriction of physicians' use of methaqualone to hospital pharmacies because of its abuse potential. The council extended the scope of its considerations to alert all physicians to "the problem posed by the continued abuse of this drug and the possible alternatives to its use in the treatment of sleep disorders."

Several states already have placed stringent controls on methaqualone — best known under one of its trade names, Quaalude — because of its persistent abuse on the street. At least two states, Florida and Georgia, have removed methaqualone from medical practice by classifying it as a drug with no accepted medical use.

Drug Abuse Warning Network (DAWN) data show there has been a dramatic jump in the number of drug-related emergency room admissions involving methaqualone, up from 13th place in 1978 to fifth place in 1981.

The AMA council report points out, however, that in only 7% of the cases was the drug obtained by a legal prescription.

"Substantial quantities of methaqualone, both genuine and counterfeit, have been produced in other countries and smuggled into the US," the council said, adding that "such illicit sources have been responsible for much of the street-use of the drug."

In addition, it said, drug-abusers obtain methaqualone taken in pharmacy break-ins and through inappropriate prescribing.

The *AMA Drug Evaluations* considers methaqualone an effective sedative and hypnotic agent, but notes that, like similar drugs, it may lose its effectiveness by the second week of continued administration. "It appears to have no advantage over other hypnotics," the council says.

The drug may derive its popularity among abusers from the fact that it has a rather rapid onset of action, the council observes.

In 1980, the AMA adopted an earlier council report recognizing the important place sedative hypnotics have in medical practice and affirming resistance to any reduction in the number of drugs available to the physician because of the abuse potential. At that time, however, the council also recommended physicians determine in every case whether a patient might be helped by means other than drug therapy or whether drugs other than sedative hypnotics might be used.

In its recent report, the council suggests benzodiazepines, prescribed for sleep disorders, might be an effective option for some patients. Medical use of methaqualone has, in fact, been declining, it said. The US Drug Enforcement Administration production quotas for the drug have dropped 60% since 1981, and the AMA council said: "A further decline may be anticipated if physicians further reduce their prescribing of methaqualone."

Young often unable to be flexible

Parental alcoholism taxes child

PHILADELPHIA — Children living in a family with an alcoholic have to cope with so much that they are unable to learn to be flexible and spontaneous.

"Education is only the first step: we need to provide a therapeutic service in order to teach them the many things they have never had an opportunity to learn," believes Claudia Black, an alcoholism consultant in Newport Beach.

Ms Black told the National Conference on Alcoholism and the Family here that most of these children see things as black or white. They must achieve the ability to "to play, to relax, and not to be afraid to have feelings, cope with them, and express them."

All too often it is forgotten that children have fewer resources than adults: mentally, physically, and emotionally, said Ms Black. And children living in families with an alcoholic are even more vulnerable.

Many of them don't get proper rest because of arguments by their parents in the next bedroom; often they don't get proper nutrition, many suffer physical or sexual abuse, and many are hyperactive or asthmatic.

Ms Black said that as the children grow older they gradually withdraw from intimacy with their friends because they feel they cannot be honest about what is going on at home. At school they are preoccupied with thinking about what happened at home the night before, or what might occur when they get home from school that day.

Many survive, but at a price. Ms Black said that by the age of nine, their sophisticated denial makes it difficult to identify and work with them; it even makes it difficult for the child to reach out and ask for help.

One reason children do not talk is because their parents have told them not to, and particularly not to refer to a parent having a drinking problem or possibly being an alcoholic.

Ms Black said the single most important ingredient in treatment of these children is honesty on the part of counsellors. "And they must be consistent and predictable in that honesty."

In this way, children will become honest with themselves and will have to be honest about what is going on in their families. Then they can learn to express helplessness, hopelessness, and despair, and to acquire flexibility and spontaneity.

U of T professor wins Keller award

TORONTO — Mary Jane Ashley, MD, is the 1983 recipient of the Mark Keller Award for her review in the scientific literature on alcohol consumption and heart disease.

The award committee selected Dr Ashley's work as "the best and most significant report" to appear in the *Journal of Studies on Alcohol* in 1982.

Ashley

Dr Ashley is professor and chairman of the department of preventive medicine and biostatistics, faculty of medicine at the University of Toronto here, and is also a consultant to the Addiction Research Foundation of Ontario.

The title of her article is Alcohol Consumption, Ischemic Heart Disease and Cerebrovascular Disease: An Epidemiological Perspective.

The Mark Keller award is presented annually by the Center of Alcohol Studies, Rutgers University, New Brunswick, NJ.

It is "presented to the author or authors of that scholarly report published in the *Journal of Studies on Alcohol* in the preceding calendar year that not only possesses a high degree of research competence, but also, through its communicative style and broadly relevant implications, contributes to innovative and provocative thinking, as judged by the Mark Keller award committee," said Larrissa A. Pohorecky, PhD, associate professor at the Center of Alcohol Studies, and chairwoman of the award committee.

The 1982 recipient of the Mark Keller award was Barry Tuchfeld, PhD (The Journal, June).

Doctors asked to support raise in US drinking age

By Charles-Gene McDaniel

CHICAGO — Physicians in the United States are being asked to join in the campaign to raise the minimum legal drinking age to 21 years.

The American Medical Association's (AMA) House of Delegates, its policy-making body, have adopted a resolution calling for state medical societies to seek and support legislation to achieve this goal.

The resolution urges "all physicians to commit themselves to taking every available opportunity to educate their patients about the dangers of alcohol abuse in general and operating a motor vehicle while under the influence of alcohol in particular."

Introduced by the Wisconsin delegation at the annual meeting here of the AMA, the resolution cites alcohol as "the number one killer" of young male drivers, 18 to 21 years old, in the US.

Fifteen states have set 21 years as the minimum legal age to purchase any alcohol, and 15 states and the District of Columbia have set that age as the minimum to purchase spirits.

Because the legal drinking age is not uniform nationwide, thousands of young people cross state lines to drink, and their driving causes a health and safety hazard to themselves and innocent citizens, the resolution points out.

Another resolution encourages the radio and television media to refuse advertising of alcoholic beverages.

"People in general, but particularly children and adolescents, are strongly influenced by what they see on television and hear on radio," it says.

A resolution introduced by the Resident Physicians Section also addressed the issue of advertising and commended "those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol."

AMA gift honors Nancy Reagan

CHICAGO — The American Medical Association (AMA) is donating $5,000 to the National Federation of Parents for Drug-Free Youth in honor of Nancy Reagan.

Announcement of the donation to one of the United States' First Lady's favorite causes was made by Dr Harrison Rogers of Atlanta, Ga, speaker of the AMA's House of Delegates during his introduction of President Ronald Reagan, who gave a speech that concluded the annual meeting of the 351-member House, the AMA's policy-making body.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Smokers not hoodwinked

Ads are vastly overrated

Occasionally I read articles which fill me with such fury that I am prompted to air my opinion In the **July** issue of **The Journal**, I read not one but two such articles.

I am a moderate to heavy smoker (depending on my workload, activities, and surroundings), and have smoked for the past 18 years. I never smoked in my teens although many of my friends smoked, as did my father. I do, however, have consideration for non-smokers and will always put out a cigarette at someone's *polite* request, or even ask non-smokers if they object before lighting a cigarette (the "kick-the-habit" fanatics seem unaware that many non-smokers have no objection to people smoking around them). But no smoker will pay attention to these fanatics unless they make sense — quite the contrary.

The first article to which I refer is on page 6 — (BC) Stadium Bows to pressure.

It is my opinion that it is thoroughly stupid for anyone to believe that the presence or lack of tobacco advertisements will in any way influence a person's desire to smoke.

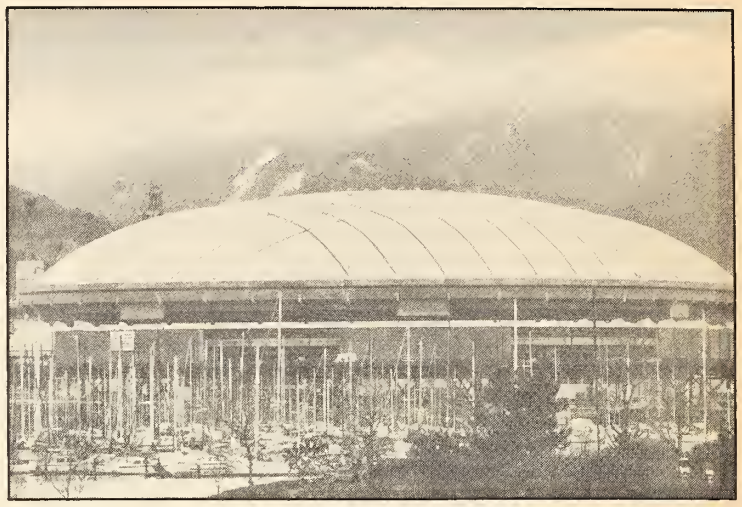
Most smokers I have spoken to were already 'confirmed' smokers before they saw a tobacco advertisement; on the other hand, my non-smoking friends are not prompted to smoke because they constantly see tobacco advertisements. For example, I thoroughly enjoy the television beer commercials, and I am not even slightly tempted to try one beer or another since I dislike the taste of beer.

On page 11 there appears a picture of the Royal couple and their son, under which one reads comments by Canberra's cancer society chairman and David Simpson of Action on Smoking and Health. If the ad had been one of Seagram's, would that have meant the Royal couple were alcoholics?

Do these idiots think we cannot recognize an ad for what it is, ie exactly that — an ad? If the public at large supposedly lacks the intelligence to separate the Royal visit from a cigarette advertisement, then I am forced to believe that the Royal couple is involved with Ireland's being the newest drug-transit point in Europe since their picture on page 11 of **The Journal** appears to form part of that article.

I am quite willing to be convinced that smoking is detrimental to my health and possibly to the comfort of others, but I abhor these fanatics who have nothing more convincing to show me than the location of a cigarette advertisement in a newspaper.

Mrs M. Baziw
North York, Ontario



BC stadium: ad restrictions are stupid, says reader

Drugs and crime abroad

The Institute for the Study of Drug Dependence in London has sent us a copy of the piece in **The Journal** entitled It's no holiday — poster warns smugglers (**The Journal**, June).

This organization deals with Britons arrested overseas and it is a fact of life that most crimes committed abroad are drug-related.

We were most interested to read that your department of external affairs is also taking this subject seriously, and obviously we would like to have some contact with Robert Lapointe, the consular policy officer involved in organizing the program.

Joe Parham
National Council for the Welfare of Prisoners Abroad
London, England

TJ provides new resources to investigate

Thank you for a very worthwhile "read" every month. I comb **The Journal** regularly, with it providing at least four or five resources to investigate further.

Donna J. Sim
(Coordinator)
Suicide Information and Education Centre
Calgary, Alberta

Teen Titans interesting

I read in the June issue of The Journal **a very interesting article concerning a comic book and its efforts to involve the private sector in drug abuse (The New Teen Titans combatting drug use comic-book style).**

The comic book is based on the New Teen Titans and developed by DC Comics and Keebler Company.

Can you please advise me where I can obtain a copy.*

Shirley Ward
Chatham, New Brunswick

**Write to: David Mishur, Public Relations Manager, Keebler Company, 1 Hollowtree Lane, Elmhurst, Illinois 60126.*

Ads should be analyzed

The Journal interests me as a result of the serendipity we often find in group therapy.

I am now in treatment for alcoholism and, during a discussion group, we talked about the problem of ignoring beverage advertisements and point-of-purchase displays while trying to stay sober. My feedback was biased toward analysis of the marketing strategy itself and its particular appeal to the market it is trying to reach, rather than trying to ignore it.

I believe this approach is good for a recovering alcoholic because it has worked for me; and, believe me, I *need* results. If anything, this approach might help all consumers in all areas of commercial message bombardment.

Shortly after this group, I read the articles, Beverage Futures, and Beverage industry thwarts controls, broad-based counterattack needed (**The Journal**, June), in my therapist's office.

As a former financial reporter and editor, I've sat through many an industrial seminar and have been unable to cover the proceedings from anything other than a commercial point of view, *vis a vis* a consumer "slant." I envy "you all."

Keep up the good work. Congratulations on a superior monthly. (I love your layout.)

Jim Parks
Sylacauga, Alabama

Correction workers' stress probed as drug, health concerns surface

By John Ingalsbe

TORONTO — Believing that a serious alcohol and drug abuse problem exists among Ontario corrections officers, the union representing the guards has commissioned a $30,000 study into the effects of stress in corrections work.

"The study will concentrate on various kinds of substance abuse, but we also want to look at the various areas of stress and examine family relations as well," says Kevin Wilson, executive board member of the Ontario Public Service Employees Union (OPSEU), which represents about 2,800 corrections officers at 48 provincial institutions.

Conducting the study will be Jeanne Stellman, PhD, associate professor of health at Columbia University, New York, NY. It will be carried out at designated institutions over a six- to nine-month period starting in September.

The OPSEU approved funding for the Columbia study after its own preliminary survey found a significant number of corrections workers were experiencing stress-related problems such as coronary disease, ulcers and other digestive disorders, mental illness, and family breakdown, as well as substance abuse.

In a brief presented earlier this year to the Ontario ministry of correctional services, the union acknowledged that much of its information on the physical and psychological effects of stress on these workers is "impressionistic." However, it also cited data from one institution which, it said, proves problems do exist.

Of 127 employees in the 20- to 40-year age group at the Oak Ridge Maximum Security Institution, 48 have chronic or acute health problems, and there is significant absenteeism due to drinking in the rest of the group, the brief says. Of 27 employees in the 40- to 50-year age group, 17 had serious health problems and all the rest were considered "heavy" drinkers.

"This has always been a very stressful occupation, but the problem has been magnified in the last couple years as the inmate population has increased," explains Mr Wilson, who has four years' experience as a corrections officer and is now a rehabilitation officer at the Don Jail here.

Overcrowding is a major factor in causing stress, the OPSEU says. Ontario statistics state that admissions to the province's jails increased by more than 8% from 1979/80 to 1980/81, when there were 76,981 admissions. The union says the increase is due to a higher arrest rate, stricter sentencing, new bail restrictions, and the closure of many of the province's psychiatric hospitals.

Overcrowding has made it difficult to carry out rehabilitative programs and made inmates more disruptive, thereby increasing the danger of corrections work, the union says. It also charges that prisons are understaffed and rely too much on inexperienced temporary personnel, and that guards do not have enough say in formulating procedures and do not receive adequate training in human relations.

Unworkable administrative procedures, the para-military structure of the prison system, as well as shift work, contribute to the overall problem of job stress, Mr Wilson told **The Journal**.

"We'd like to see programs to deal with stress set up at the worst institutions first but we're also trying to get the ministry to recognize that stress could be reduced by negotiating changes in the system itself."

The government admits that overcrowding is a problem. Corrections Minister Nicholas Leluk said in his 1982-83 Estimates Brief that the increase in inmate population in the past year "has severely taxed our facilities." He told the Ontario legislature in January that he expected an increase of more than 2,500 inmates by 1985.

Corrections: always stressful

While the ministry recognizes that corrections officers work under considerable stress, it does not recognize any major health problems among them.

"We have no concrete evidence that alcohol or drug abuse is or is not a problem, simply because there is no research in the area," Vic Crew, director of the ministry's personnel branch told **The Journal**.

"Our average absenteeism is surprising. It's somewhat below the service-wide average. But I wouldn't conclude that this means these workers aren't suffering stress, it's more because they're dedicated and want to come to work."

Mr Crew said that in the past year the province has begun to set up employee assistance programs (EAPs) through a joint government-union committee. (**The Journal**, June, 1982). While the major function of EAPs is to refer employees with substance abuse or other problems to agencies that can help them, they can also provide useful research data, he said.

"We would like to see joint government-union research on the (alcohol and drug abuse) problem done through the joint committee."

Mr Wilson told **The Journal** that the Columbia study would not close the door on such joint research.

Fetal alcohol syndrome

Research has generated 'mixed messages'

By Harvey McConnell

BOSTON — Henry Rosett, PhD, believes he has said all he can about drinking, pregnancy, and the fetal alcohol syndrome (FAS). Now he wants to explore other avenues in medicine.

With publication next year of a book, *Alcohol and the Fetus*, he completes a decade of study and debate, spurred on by a course in alcoholism at the Addiction Research Foundation in Toronto, culminating in voluminous entries in the literature on drinking and pregnancy.

But as he continues his full-time work as a psychiatrist at Boston University, perhaps pondering research into styles of thinking and personality, he says two key words — guilt and credibility — need to be spelled out to the public and profession about FAS.

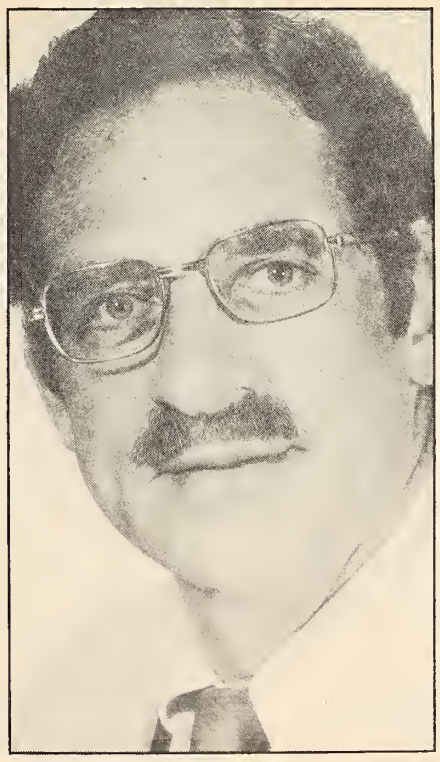
The mixed messages produced by research into FAS have generated unfounded guilt in many women who have had a baby with a major or minor anomaly and who believe, incorrectly, it may have been caused by their moderate drinking during pregnancy.

The same mixed messages have produced a credibility debate among many obstetricians and gynecologists, and hindered efforts to get them to take drinking histories of patients and try to counsel women who are heavy drinkers.

Dr Rosett told **The Journal** that he doubts "consumption of less than one ounce of alcohol, one or two drinks, has resulted in any adverse effects on the fetus. There is evidence of FAS only in cases of babies born to women who are drinking more than five or six drinks on occasions."

In the soon-to-be-published book, he and colleagues at Boston City Hospital have reviewed "both the human epidemiological studies as well as experimental data with mice, rats, beagle dogs, and monkeys, which show that low doses of alcohol have no adverse effect on the morphology or behavior of the fetus."

Dr Rosett said the exaggerations of the risks of small amounts of alcohol during pregnancy have created major problems.



Rosett: risks exaggerated

He elaborated: "I think that if a woman is concerned then the most conservative thing she can do is not to drink. There is no doubt about that.

"I think the disadvantage of this is that there are women who have children who are either retarded, or malformed, or a thousand other things, who end up feeling guilty that a small amount of alcohol may have caused this.

"This can have adverse effects on the mother's mental health and her relationship with the children."

As for the medical profession, "we are trying to convince obstetricians and gynecologists to take drinking histories.

"They point to these data about small amounts of alcohol perhaps being harmful, and they talk about their vast experiences with thousands of women — even their own wives — they have known who have had small amounts of alcohol and delivered outstanding children."

Thus the strong data about the adverse effects of heavy drinking are diluted and mixed with all the other information which is not as strong.

"I think that if we can convince doctors to counsel those women who are drinking heavily to try to stop their drinking, doctors will see the benefits and this will reinforce their interest in continuing to do this," he added.

Doctors will do what they see will benefit their patients, and they are not indifferent to being helpful. "But they are not going to take drinking histories if they are not convinced it is going to make a difference."

Dr Rosett is heartened by moves now being made in the profession to try to get doctors and other health professionals working with pregnant women to identify those heavy-drinking women who are at risk, and to get them to try to stop.

He realizes "unfortunately, a lot in science depends on one's perspective and ways of thinking, and that is one reason why people get a particular (mind-)set. They look at the data in a particular way and they keep reinforcing the way they think.

"That is one reason I am wrapping up my fetal alcohol syndrome research because I don't want to keep saying the same thing the rest of my life."

He first became particularly interested in drinking and pregnancy following his course at the ARF. "I came to feel that there was a dose response and there might be certain effects on formation of the fetal organ systems in the first trimester which would not be reversible, but that impairment of the central nervous system development, which occurs in large part in the third trimester, would, if the woman stopped drinking."

At about the same time, he wrote a letter to *The Lancet* to protest what he considered an exaggeration of studies connecting drinking and spontaneous abortions. He did not believe the conclusions were supported by the evidence.

Dr Rosett points out: "I am really a practicing psychiatrist and I got into this in a funny kind of way. I had come to Boston University for a career teaching addictions and began by taking medical students to skid row, detoxification centres, halfway houses, Salvation Army centres, and that sort of thing.

"But I found after I had done that it only reinforced the students' prejudices against alcoholics."

He searched for a group of patients with whom the students could have a different kind of experience, and to change the stereotype, "and I thought of young women."

He visited the prenatal clinic at Boston City Hospital "primarily with the idea of looking into child abuse, and I found child abuse seemed to be associated with drinking parents.

"It was at this time that FAS was described (in the literature) and we decided to do a prospective study. This is how you can fall into things."

Although about 75% of his time over the years has been spent as a practicing psychiatrist, he said "I got emotionally involved in this research."

Dr Rosett and his colleagues stopped collecting data in 1979 and have spent the intervening years collating, analyzing, and publishing in the literature, trying "to reach the practicing doctor and not the alcoholism specialist."

Now he wants to turn to other things. "I feel that I have been repeating myself and that I have said what I had to say. When we complete this book I think somebody else should come along and come to their own conclusions.

"I think what we have done stands by itself. I am personally satisfied. I wanted to make a scientific contribution which remains after I am dead and buried, and I have not published something or said something which is not the truth as I see it.

"Other people see the truth differently and feel differently about it. But we have been having disagreements all these years, and I think the next generation should come along and reach their own conclusions."

NEWS

Moderate drinking enhances intimacy US survey finds

By Harvey McConnell

HOUSTON — Women who are moderate social drinkers appear to have fewer sexual problems than abstainers or light or heavy drinkers.

A survey of a national sample of women in the United States by Sharon Wilsnack, PhD, associate professor of behavioral science, and colleagues at the University of North Dakota, Grand Forks, found that some of the stereotypes about women and drinking were true and some were not.

Overall, 60% of drinkers feel less inhibited about sex, 62% feel closer to a person they share drinks with, 69% find it easier to be open with other people, and 45% find sexual activity is more pleasurable.

But drinking does not produce a promiscuous woman, the study says. Only 22% said they became sexually forward when they had been drinking, and only 8% said they were less particular in their choice of sexual partners when they had been drinking.

However, 60% reported that someone who was drinking with them became sexually aggressive.

The study, which Dr Wilsnack presented at the annual conference of the American Medical Society on Alcoholism here, was carried out in 48 states among 500 moderate- to heavy-drinking women, 39 women who were former problem drinkers, and 378 light drinkers or abstainers.

Dr Wilsnack told **The Journal** women still appear more likely to be targets than initiators of drinking-related sexual aggressiveness.

The word "aggressive" was deliberately chosen. She said: "While it can mean different things to different people — ranging from someone making a 'pass' to rape — if they view the act as sexually aggressive then this is important information regardless of what actually happened.

"Aggression implies to me something that is more than just attention from someone you wanted attention from."

Women: more likely targets of drinking-related aggressiveness

Dr Wilsnack said there were two possible reasons why women who were moderate drinkers reported fewer sexual problems.

"Perhaps moderate amounts of alcohol have a mildly facilitating effect on sexual function. The other possibility is that in lighter drinkers there is a greater inhibition or suppression that affects both drinking and sexuality, and at heavier drinking levels the alcohol may be causing sexual problems or be used by women to treat the problems."

What is a surprise, "and we don't know what to make of it," said Dr Wilsnack, are the findings among women who have consumed alcohol in the past 12 months but not in the 30 days prior to the interviews. These "temporary abstainers" had the highest levels of sexual dysfunction of any group.

Dr Wilsnack: "What we are speculating is that these are women who have gotten scared about their drinking, they have been having problems, including sexual problems, and may perceive these are alcohol-related or are being made worse by alcohol.

"Or perhaps they are using alcohol to self-medicate their sexual problems, but it is not working, so they stop."

This same group had the highest rate of gynecological and obstetrical problems.

Overall, the study suggests that

Wilsnack: sensitize professionals

professionals concerned with women's sexual and reproductive health should be alert to alcohol abuse as a possible antecedent, accompaniment, or consequence of the sexual or reproductive problems they are treating.

At the same time, professionals treating women's alcohol abuse should be alert to associated risks of sexual and reproductive dysfunction.

"We really need to get the health providers sensitized to these women at risk of alcohol abuse and to make them an important target group for prevention efforts," Dr Wilsnack added.

The study was co-authored by Albert Klassen, MA, senior research associate, and Richard Wilsnack, PhD, both of the department of sociology at the University of North Dakota.

Self-prescribing doctors are 'foolishly confident'

By Incor Jowat

TORONTO — Doctors need to be more careful about self-administering drugs because of the potential dangers of addiction, says the deputy registrar of the College of Physicians and Surgeons of Ontario.

H. William Henderson, MD, described the type of doctor who becomes addicted to alcohol or drugs and ways of treating the problem in a paper presented here at the annual meeting of the College of Family Physicians of Canada.

Dr Henderson said there appear to be three main routes to drug addiction for physicians.

"Some doctors start with self-administration of drugs to relieve pain and discomfort," he said. Some, with a history of problems with alcohol, are prone to try various drugs. Others, who have experienced the comforting effects of a narcotic prescribed to relieve severe pain, sometimes return to the drug years later to recapture the feeling.

"Physicians have easy access to drugs, and, unfortunately, there is a tendency for physicians to prescribe for themselves," Dr Henderson said.

He said it is surprising how often doctors will assist a colleague in obtaining drugs "when they have reason to question whether the medications they prescribe will be used appropriately.

"All doctors are superbly and foolishly confident they can control their use of drugs," he said, just as they are sure they can control alcohol intake.

While stress is a contributing factor, he said, "psychological factors, by themselves, do not explain why some people become dependent on chemicals whereas others, under similar conditions, do not."

Dr Henderson said changes in behavior associated with misuse of drugs or alcohol usually progress over a three- to five-year period before a crisis develops "which results in a confrontation that leads the doctor into a treatment program."

Dr Henderson, who is also chairman of the coordinating committee for a College program for doctors on chemicals, said "an increasing number of physicians in Ontario are asking for help for themselves or for a colleague."

He said there are many indications attitudes are changing in the medical profession, and a climate has been produced which encourages the early recognition and treatment of the impaired doctor.

A regulatory body, such as the College, can play a prominent advocacy role in helping the doctor, he said.

During the early stages of recovery, the College can offer the protection of controls on the physician's access to drugs sometimes by limiting prescribing privileges.

When abuse is registered and treated appropriately, Dr Henderson said, a high rate of recovery can be expected.

OMA assisting physicians with addiction problems

By Betty Lou Lee

TORONTO — The Ontario Medical Association (OMA) has established a section to deal exclusively with addiction problems among doctors.

The section was approved by the OMA council at its annual meeting here to reduce the prevalence of alcohol and other drug misuse "in our profession and in the community." Seventy-one physicians supported the initial application.

Robert H. Johnson, MD, staff physician at The Donwood Institute here, told **The Journal** the problem of addictions hasn't specifically been dealt with before by other OMA sections, and the impetus for the new section came largely from three groups: Donwood staff members, doctors in a recovery group, and members of the Courtney Club, which includes spouses.

Dr Johnson: "We hope it will be a forum in which doctors early in their use can talk about themselves without the discipline of the College (the Ontario College of Physicians and Surgeons), or the attitudes of some older physicians with the idea it's a moral issue.

"We hope it will be a neutral place to phone. We have liaison with both the College and the OMA, and we can show people how to get help."

It's not only for doctors whose problems are personal, Dr Johnson added. Section members have an overall knowledge of treatment facilities in Ontario and can advise a physician about appropriate options for patients.

The section has set up four ongoing subcommittees. Dr Wallace Lotto of Toronto heads the one for disabled physicians; Dr Maris Andersons of Toronto, section secretary, is also chairman of the program and education committee; Dr Joseph C. MacMillan of Toronto will head the treatment committee; and section vice-chairman Dr Alan Scarth of Barrie, the research committee.

Family support essential in alcoholic's recovery

PHILADELPHIA — There is a need for an "our" program as well as individual programs to treat alcoholics and their families.

Olaf Bjornstal, director of the family care services of the Chit Chat Foundation, Wernersville, Pa, explained: "We have seen lots of problems in recovery with one person going to AA (Alcoholics Anonymous) and getting sober, and a spouse or close relative going to Al-Anon and getting well, but they never take part in an 'our' program."

The first need is for individual recovery for both the alcoholic and family members. "And each person ought to have the right to a separate recovery without interference. But at an appropriate time they should be pulled together, maybe something which could be called 'family anonymous.'"

Mr Bjornstal was speaking to the National Conference on Alcoholism and The Family here. He said many in the treatment field have observed how sad it is to see people who have been in programs such as AA and Al-Anon for a number of years, "but it does not seem they are together, and I don't mean in their head, but as a couple, or as a unit."

Italy, Pakistan source countries

Cheap heroin floods eastern US

CHICAGO — The eastern seaboard of the United States is being inundated by heroin originating in Italy and Pakistan, says John Warner, chief of the international program of the US Drug Enforcement Administration (DEA).

Mr Warner said the availability and abuse of heroin is increasing again in the US after levelling off for a number of years. In 1982, the purity of heroin rose to an average of 5.1%, up from 3.9% in 1981.

The decreasing price is another indication of increased supply, and the number of deaths and injuries resulting from heroin abuse has risen by one-third since 1979, Mr Warner told the 7th World Conference of Therapeutic Communities here.

He said that 50% of the heroin reaching the US comes from opium grown in Pakistan, Afghanistan, and Iran (**The Journal**, July). The majority of refining is done there and the rest of the opium is processed in Italy and Sicily.

India produces opium legally for pharmaceutical purposes but some of it is being diverted into illicit trafficking.

He said also that the availability of cocaine in the US has increased, and that it is likely to remain at the present level: 30 to 60 tons are imported annually, mostly from Colombia. Cocaine seizures have doubled since 1981.

The use of marijuana and hashish by US high school students is levelling off and perhaps even declining (**The Journal**, April) but "we're certainly not over the hump," he said.

Warner

Mr Warner attributed the drop in high school use of marijuana to a change in the public's attitude toward the drug, but he said domestic, illicit production of cannabis "is a major problem."

Some 51% of the marijuana entering the US comes from Colombia; 16% from Jamaica; 6% from Mexico. Belize and other countries supply a further 6%, and the remaining 21% is produced domestically, Mr Warner told **The Journal**.

He terms US production of marijuana a "most alarming" development: a few years ago only 7% was produced domestically.

Alcohol education: realism must supersede faith

ZAGREB — Hazardous fallout caused by an international trend to make alcohol more easily available may tax the resources of agencies attempting to educate the public about misuse.

"The prevailing attitude is toward more and more outlets, less expensive beverages, more self-serve facilities, longer hours, and more opportunities for consumption," says Henry Schankula, director of education resources at Ontario's Addiction Research Foundation (ARF).

This "further liberalization will no doubt have an upward influence on consumption or at least the maintenance of existing levels," Mr Schankula said at a seminar on alcohol education at the 29th International Institute on Prevention and Treatment of Alcoholism here.

He pointed out the great failure of alcohol education and prevention programs is they don't apply the most common elements of managing by results.

Schankula: decay effect

Mr Schankula: "How can we possibly measure the influence of a small breath of information, knowledge, or gentle persuasion as might emanate from an organization dealing with the hazards of alcohol use? By comparison, hurricane winds come from the beverage industry."

To gauge the effect of any alcohol education program, Mr Schankula said, planners must rigidly and conscientiously apply the following criteria:

- programs must be time-limited, with a specified starting and ending date;
- the target audience must be determined and communication processes that might affect this group must be identified;
- the objective must be realistic; and
- the efforts must be measurable — programs should not be operated on faith alone.

The interaction of the first three criteria (time-limited, specific, realistic) contribute greatly to the project's measurability, Mr Schankula said.

"Our experiences with short-lived, time-limited activities that have increased knowledge or reinforced beliefs and modified attitudes can be readily identified. However, major cataclysmic changes in behavior as a result of an education program appear to be rare."

He cited the Metropolitan Toronto RIDE (Reduce Impaired Driving Everywhere) program operated by the Metro Toronto Police with assistance from the ARF as an example of a time-limited program which achieved positive results. (**The Journal**, Feb 81).

As a result of the program and the mass-media attention, public knowledge of drinking and driving laws increased dramatically, he said. However, he pointed out, there appears to be a "decay effect" as attention to the program diminishes.

"Even if appropriate knowledge levels are achieved and attitudes in the wished-for direction are in place, the desired change will nevertheless still take time," he said, adding, "dramatic shifts can be anticipated and measured only over generations." This type of long-term attitude change is now beginning to be seen in the area of smoking, he said.

Addiction on increase in Europe's minorities

By Charles-Gene McDaniel

CHICAGO — Drug addiction is a growing problem among minorities in the now multi-racial societies of The Netherlands and Sweden.

The problem was discussed in a workshop during the 7th World Conference of Therapeutic Communities here.

Jan VanDerKoogh of the Emiliehoeve Therapeutic Community (TC) in The Hague, said large-scale immigration began when Holland started losing its colonial possessions after World War II.

The Indonesians, mostly of mixed race, "have assimilated completely in Dutch society without causing any specific problem," he said. But this has not been so with the Moluccans, natives of the so-called Spice Islands off Indonesia, he said.

The Moluccans arrived in Holland between 1948 and 1952 after losing their war for independence from Indonesia. They planned to stay temporarily and then to return to liberate their islands with the aid of the Dutch.

They "never mixed with or assimilated to the Dutch society and stayed in the temporary camps they were put in after their arrival in the country."

In 1978, when Surinam, formerly Dutch Guinea, became independent, there was another influx of immigrants, with 350,000 of the 800,000 inhabitants of that country arriving in Holland. There, they were told, "it was easy to become rich."

Mr VanDerKoogh said a serious drug problem developed among the second-generation Moluccans, and they hesitated to enter the Dutch treatment programs. When they did so, he said, they tended to leave early unless they found other Moluccans already in treatment.

He said the Emiliehoeve TC became more successful in treating Surinamese addicts after the staff became more sensitive to their culture. He said, for example, these addicts consider washing dishes and housecleaning to be women's work. Offended at being asked to help in these chores, they would leave. The TC also learned to add spices to the Dutch food, which the Surinamese find too bland.

Originally, too, the staff did not permit the Surinamese to speak their own language because they thought it was addicts' street talk.

Mr VanDerKoogh said the TCs are doing better with these immigrants than with native Hollanders. One reason, he said, is that they enter through the judicial system as an alternative to jail; another is that the outside environment is hostile to these people.

Anette Pettersson of the Vallmotorp Foondation in Stockholm said her country's "very generous immigration policy" has led to an influx of immigrants from Finland, Yugoslavia, Turkey, and Greece, with the largest group coming from neighboring Finland.

Many of these immigrants came to take advantage of job opportunities that no longer exist; others are family members who came to join the workers.

The primary drug problem is among the Finns, who are now second generation, Ms Pettersson said.

The lack of a security network and of an identity contributes to the drug problem among Finns, she said. Yet, they are reluctant to return to Finland because punishment for drug crimes is more severe there.

Ms Pettersson said there are no bilingual TCs in Sweden, although efforts are being made to start one for Finns; however, it is difficult to find staff for such a TC.

Short, European flights may be affected

Airlines study smoking ban

By Thomas Land

GENEVA — The Association of European Airlines will consider formal proposals for banning all smoking in short-haul flights.

Many airlines in North America and elsewhere are likely to consider the idea seriously following the recent death of 23 Air Canada DC9 passengers in a fire initially believed to have been caused by a cigarette left in a lavatory. (A defective flush motor in the lavatory system was later suspected.)

Airlines favor smoke-free flights for many reasons, including safety, economy, health, and hygiene. But they fear resistance by tobacco-addicted passengers. Aeroflot, the Soviet airline, has already banned smoking on board its domestic flights. Other airlines are studying its experience with interest.

The proposal for the introduction of smoke-free flights on the short-haul sectors of European scheduled air services is to be put forward by the Scandinavian Airlines System (SAS), and backed by several other airlines. But the issue is unlikely to be resolved at this stage.

Some airline safety specialists argue that the inflammability of plastic cabin linings and fittings necessitates a total ban on smoking. Others fear that a consequence of such a ban might be illicit smoking during flights, leading to an even greater fire hazard.

Heavily addicted smokers deprived of nicotine may take extraordinary risks to satisfy their craving. A fire aboard a Boeing 707 aircraft just before landing at Orly airport in Paris 10 years ago was started by a concealed burning cigarette, and it killed 115 passengers in a smoke-filled cabin.

Western airlines are therefore showing interest in the Soviet experience in persuading passengers to refrain from smoking.

Aeroflot's no-smoking regime in all its domestic flights — many of them long-range — officially came into force this year. But it follows several years of experimentation with the patience of travellers facing "no-smoking" signs deliberately left switched on during entire flights.

Aeroflot says its research has established that smoking reduces the resistance of passengers to airsickness as well as stress during take-off and landing and to oxygen deficiency at high altitudes. Aeroflot pilots are also forbidden to smoke before and during flights.

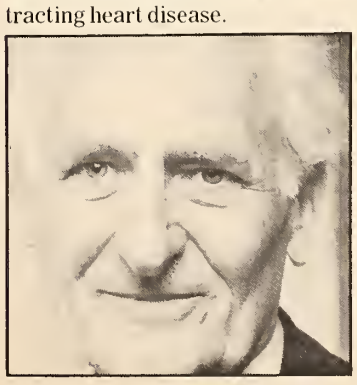
Smoking ban: some passengers may not be ready

Research involving Aeroflot's pilots suggests that a single cigarette before a flight can significantly reduce a person's ability to adapt to darkness and to discern colors.

The SAS believes that smoking will be banned from Europe's skies in the long-term, although some airlines and their passengers may not yet be ready for such a move. In the meantime, the SAS is about to introduce a new computer system to improve seat allocation procedures for the separation of smoking and non-smoking passengers.

Cigarette-cancer man warns of heart risks

LONDON — Low-tar cigarettes could halve the chance of smokers contracting lung cancer, but they will not reduce the chances of contracting heart disease.



Doll: low-tar is dangerous

Sir Richard Doll, director of the Oxford University epidemiology unit, and the first person to publish conclusive epidemiological links between cigarette smoking and lung cancer, said in a report for the Imperial Cancer Fund that cigarette smoking is responsible for 30% of all deaths from cancer.

Low-tar cigarettes appear to reduce the chances of a smoker developing lung cancer, but they are just as dangerous as high-tar cigarettes in increasing the risks of heart disease, he said.

A further 30% of cancer deaths could be averted by changes in the western diet, in particular by reducing the consumption of animal fat, he said.

Tuyns named '82 winner of Jellinek award

ZAGREB — Albert J. Tuyns, MD, of the Interntional Centre for Research on Cancer in Lyons, France, has been named the 1982 winner of the E. M. Jellinek award.

Dr Tuyns received the $5,000 award for his contribution to the understanding of the significance of alcohol consumption in the etiology of conditions important to clinical medicine and public health, specifically for his work on the relation between alcohol and cancers of the upper gastrointestinal tract.

Dr Tuyns, a graduate of the University of Brussels, has also done work in the epidemiological analysis of the relationship between the level of alcohol consumption and the incidence of various forms of organic pathology.

The award is presented annually by the board of directors of the Jellinek Memorial Fund to the scientist or scholar who has made a significant contribution to the advancement and knowledge in the alcohol field.

The 1981 winner was Dr Wolfgang Schmidt, director of epidemiology at the Addiction Research Foundation of Ontario, for his epidemiological research in the alcohol field and in particular that relating to physical health consequences of heavy drinking. (The Journal, Apr 1981).

NEWS

Fear of looking soft on drugs gags some workers

WINNIPEG — There is little evidence to support the theory widely held by psychologists that exposure to an opiate creates a tendency to subsequent addictive use, says a British Columbia researcher.

Indeed, "most people who are exposed to opiate drugs do not continue to use them. And many who do continue stop later," Bruce Alexander, associate professor of psychiatry, Simon Fraser University, Burnaby, BC, said here.

Those who do support the theory "appear to have been dazzled by loud and dramatic stereotypes" and "media dramatizations of the hapless junkie and the fiendish pusher," he told the Canadian Psychological Association annual meeting.

While he admitted his colleagues may be intimidated by popular culture and by fear of appearing foolish or "soft on drugs," he chided them for lacking courage.

"The role of empirical psychology is to inform itself and the public (of its findings) with perspicacity and courage. I have learned . . . never to underestimate the perspicacity of my colleagues. So I can only presume it is courage that has been lacking."

In his critique of exposure orientation, Dr Alexander said less than 1% of medical patients exposed to regular doses of opiates during treatment in United States hospitals become re-addicted after release. In England, heroin has been widely used for decades in treating coughs, diarrhea, and other illnesses, and virtually no addicts have been created by the practice, he said.

It is estimated there are 3.5 million casual users of heroin in the US, compared with half a million addicts, he said. Further, there are many documented cases of regular but non-addictive opiate use, with no increase in regular dose over a period of time and no serious withdrawal symptoms during abstinence.

If exposure caused addiction, casual use would be a rarity and regular but non-addictive use would seem "almost impossible," Dr Alexander said.

He also said large numbers of heroin addicts stop using the drug or shift from addictive to casual use, refuting the idea that opiate addiction is interminable, with each additional exposure strengthening the habit.

But the strongest evidence against the exposure orientation comes from the case of returned Vietnam war veterans, Dr Alexander said.

While they reported heroin was readily available in the US, and many said they were occasional users, only 12% of heroin addicts among returning soldiers relapsed to addiction within three years of their return, he said.

Dr Alexander said he supports the "adaptive orientation" theory — the view that opiate addiction is not created by the drug itself, "but rather is an unsuccessful attempt to adapt to previously existing chronic stress through habitual use of opiate drugs."

He argued that the threat to empirical science "does not come from rationalists, clinicians, politicians, or even creationists. Rather it comes from the failure of empirical psychologists to be truly empirical.

"I believe it is now time for empirical psychology to re-assert its licence to lead, rather than follow, popular culture," he said.

Suicides prompt new Native treatment efforts

By Mark Kearney

TORONTO — A high number of suicides on a Manitoulin Island reserve in Ontario is prompting health officials there to step up alcohol education and mental-health programs.

The five suicides on the island (three of which were on the reserve) in the past 12 months were probably all alcohol-related, says Jack Ward, MD, clinical director of the Sudbury Algoma Hospital. This was one of the worst years for suicides at the Wikweminkong reserve, which has 3000 people, he says.

The hospital plans to develop strategies with the Rainbow Lodge Alcohol Recovery Centre on the reserve to improve the quality of mental-health care, he says.

Under the existing programs there, Native mental-health workers were hired to try to battle the suicide and alcohol abuse problems. The workers, however, have been undertrained in the past — something the hospital hopes to remedy, Dr Ward told **The Journal**.

Rainbow Lodge has been improving the situation on the reserve with alcohol education programs in the schools and by organizing group activities for the community, where drinking is prohibited, he says.

The reserve members are hampered by the poor economy and the breakdown of traditions and traditional support systems because of acculturation, he says.

"This breakdown, associated with the increasing use of alcohol, would contribute to the demoralization of a population that has little economic base to achieve an adequate living standard."

This problem manifested itself most dramatically in 1974 and 1975 when there were eight suicides on a rural part of a reserve of only 200 people. All but one of the victims was less than 30 years and "the extremely high use of alcohol by nearly everyone in the community was contributory," Dr Ward says.

Alcohol was (and is) such an essential part of the community's social life that some kind of intervention was needed, he says. Rainbow Lodge was established, and by 1980, the number of suicide attempts had been cut in half. Overall drinking seemed to decline also.

The upsurge in problems again this year will require more government funding (which he expects will be available) and effort from the reserve's mental-health workers. There will be gradual recovery "but it's going to be slow."

Ward: one of the worst years

Ontario seeks fed treatment funds

By James O'Neill

ORILLIA, Ont — Cross-sharing of program funding between provincial and federal governments is essential to future treatment of alcoholics and drug addicts, says Frank Drea, Ontario minister of community and social services.

Provincial plans to improve funding standards, and discussions with federal health officials "on a very major cross-sharing plan," may open up new areas of funding, he told delegates here at the annual conference of the Alcoholism Recovery Homes Association of Ontario, (ARHAO)

"The government funding of the 70s will probably never be back — even if the economy shows a marked recovery," said Mr Drea. "But recognition of alcoholism as part of the Canada Assistance Act is one step I should like taken, although this will not be an overnight matter.

"In society and government, we haven't yet faced up to costs in terms of human and financial resources . . . and we simply cannot do the work without the tools."

He labelled alcoholism as Canada's number one social problem — its consequences even more pronounced in this economic recession. Community support is growing tremendously, and this extended public recognition of addictions means that more cases can be treated early. However, long-term, specialized care for the more difficult cases will always be essential.

"I am optimistic of a very significant future for treatment and recovery facilities," Mr Drea said.

The theme of the conference was challenges and choices in improving recovery resources to cope with the rising incidence and diversity of addictions.

Diane Hobbs, director of detox and rehabilitation programs for the Addiction Research Foundation, said there is scope for improvement in the success rate of Ontario's detox programs. From 1974 to 1982, detox centres handled 267,713 admissions, with 55,726 of these referred to treatment/rehabilitation facilities.

"If a modest estimate of 4% are assessed as recovered," said Ms Hobbs, "this would total 2,149 successful cases. This is beyond valuation in salvaging more than 2,000 human beings and restoring them to the community. But there is scope for improvement in these figures."

Occupancy rates for Ontario's 16 detox centres usually run at 70% to 80% of capacity, but are often as low as 50%, she said, adding the basis for deciding admissions refusals, and whether communities are being fully served, should be examined.

Equally important, said Ms Hobbs, is the principle of cross-referrals between detox centres — which sometimes indulge in the practice of dumping "less amiable" residents on other facilities. More consideration might be given to whether detox centres should serve people intoxicated with substances other than alcohol — namely pills, hard drugs, or solvents. Also, greater attention might be given to the needs of women, young people, and the elderly, said Ms Hobbs.

School nurses will educate against smoking

OTTAWA — The Toronto department of public health has received $320,247 from the federal government for a program to discourage young people from starting to smoke and to help smokers quit or cut down.

The program, aimed primarily at children eight to 11 years old, will be implemented over the next 20 years and will deal with the positive aspects of not smoking.

The grant from Health and Welfare Canada will support a three-year pilot project. The city of Toronto will contribute $464,869 during the same period.

The public health nurse in each school will be the grassroots facilitator for the projects, and peer education will be used. The program will also promote legislation to cut down on smoking in public places and decrease cigarette advertising.

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DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

Alcohol and Driving

Number: 565.
Subject heading: Impaired driving.
Details: 20 min, 16mm, color.
Synopsis: Night-time scenes of drinking in a tavern are interspersed with a car being driven down a road resulting, finally, in a crash. The traffic deaths related to drinking and driving are characterized as "slaughter;" the most at-risk group being the 16- to 25-year-olds. An ambulance driver describes the horror he witnesses at such scenes and asks "Is it worth it?" Scenes of accidents and potential accidents portray what mixing alcohol and driving can produce.
General evaluation: Good-to-very-good (4.7). This film had a strong impact. It admits using scare tactics, but argues that the topic requires such an approach. Especially effective were the observations made by the ambulance driver. General broadcast was recommended.
Recommended use: Of benefit to audiences 14 years and older.

But if You Live

Number: 566.
Subject heading: Impaired driving.
Details: 14 min, 16 mm, color.
Synopsis: Every hour three people are killed in the United States by automobile accidents. In addition many people suffer brain damage and sustain other injuries, some of which maim them for life. The number one cause of death among the young is drinking and driving. Again, many are not killed but are injured so seriously that their lives are forever changed. One mother talks about founding an anti-drinking and driving organization after her 18-year-old daughter was killed by a drunk driver. A man talks about his 30 years in a wheelchair as a result of a drinking and driving accident when he was 18 years old. Scenes from a rehabilitation centre show how accident victims are helped both physically and psychologically.

General evaluation: Good-to-very-good (4.5). This contemporary, well-produced film included a lot of good information, and had a strong emotional impact. Public broadcast was recommended.

Recommended use: Of benefit to those 14 years and older.

The Special Special

Number: 567.
Subject heading: Alcohol and the family, alcohol and alcoholism-overview.
Details: 28 min, 16mm, color.
Synopsis: A family sits down to watch television. The two children and the wife appear concerned about the drinking of their father/husband. The television program shown is narrated by Michelle Lee and has an array of stars discussing all aspects of alcohol use: statistics from the United States National Council on Alcoholism; Dana Andrews discussing denial and family problems; Jason Robards discussing alcoholism in industry; Donald O'Connor — sports; Claude Atkins — treatment; Sally Struthers — youth. During the program the father is shown in conflict; drinking, wanting to turn the program off, but giving in to the wishes of the rest of the family.
General evaluation: Good-to-very-good (4.6). This contemporary well-produced film was full of good information, presented in an interesting fast-paced fashion. General broadcast was recommended.
Recommended use: Of benefit to general audiences.

DEPARTMENT

New Books

by RON HALL

Current Controversies in Alcoholism

. . . edited by Barry Stimmel

This issue of *Advances in Alcohol and Substance Abuse* addresses several of the more controversial or, perhaps, less well-known issues in the field of alcoholism. The lead paper provides a critical review of the Rand Reports, a series of publications dealing with one of the multicentre studies attempting to define the prognosis of alcoholism. The importance of a suitable study design and a random selection of people participating in any study is emphasized by the second paper. A third paper reviews the literature on group therapy for alcoholics, exploring the rationale that has allowed group therapy to become one of the most accepted forms of treatment for alcoholism. Another paper reviews the relationships among several of the more commonly utilized prevalence indicators. It is suggested that the use of combined indices reflecting mortality indicators, alcohol-related health problems, homicides, alcohol-related accidents, and suicides allows a greater degree of accuracy than addressing this problem through individual mortality variables. The authors of the fifth paper have found in a moderately sized study of marijuana use by alcoholics that almost 30% of clients admitted to an alcohol treatment program had a positive urine screen for THC on admission, with more than three-quarters of this group admitting use of marijuana just prior to their interview. The final paper deals with alcohol use during pregnancy. As discussed by the authors, the development of an arbitrary safety standard can do much psychological harm to those women who have consumed small amounts of alcohol and whose offspring are not at risk of developing fetal alcohol syndrome.

(Haworth Press, 28 E 22nd St, New York, NY 10010, 1983. 92 p. $19.95. ISBN 0-86656-225-7)

Alcohol and Youth: A Comprehensive Bibliography

. . . compiled by Grace M. Barnes

The significance and scope of this area of investigation is represented in the present unannotated bibliography of 4,662 citations related to the topic of youth and alcohol. References to literature published in languages other than English have been included, along with an English translation of each title. The majority of the citations were included only after an informative abstract or the article itself was reviewed for its relevance to the subject. Items in the bibliography are listed alphabetically by the surname of the author and are numbered consecutively. Journal titles have been listed in full and a subject index is provided.

(Greenwood Press, 88 Post Rd W, Westport, CT 06881, 1982. 452 p. $45. ISBN 0-313-23136-2)

Black Alcoholism

. . . edited by Thomas D. Watts and Roosevelt Wright, Jr

The stated purpose of this book is to bring together some of the best knowledge about the problem of alcohol abuse and alcoholism among Blacks in the United States. The focus is ultimately that of prevention. The book is divided into four major sections. The first is devoted to etiological perspectives and to a general overview of the incidence of alcoholism among Blacks and the nature of the problem. Section II is devoted to treatment: an overview of research on treatment of Black alcoholics, on what appears to work and what appears not to work, and on the treatment of Black alcoholics in the environment in which they live and work. Section III is oriented toward the problem of prevention. The relationship of alcohol abuse and alcoholism to the criminal justice system and to mental health is examined in the context of prevention efforts. The last section concentrates on policy, research, and practice implications. Finally, the appendix includes several sources that the reader might employ in further increasing his awareness and knowledge about alcoholism among Blacks. Index.

(Charles C. Thomas, 2600 S First St, Springfield, IL 62717, 1983. 242 p. $26.75. ISBN 0-398-04743-X)

Other books

Evaluation of Drug Treatment Programs — Stimmel, Barry. Haworth Press, New York, 1983. Treatment for substance abuse; detoxification from heroin dependency; methadone maintenance; individual vs group therapy in the treatment of alcoholism; narcotic agents in the treatment of opiate dependence; impact of randomized control trials on the treatment of alcohol withdrawal. 123 p. Haworth Press, 28 E 22nd St, NY, NY 10010. $14.95. ISBN 0-86656-194-3.

Directory of Alcohol and Drug Treatment Resources in Ontario 1983 — Blake, Catherine (ed). Addiction Research Foundation, Toronto, 1983. Listing of more than 250 programs including information on location, hours of service, client population, nature of service, and program description. Index. 402 p. Marketing Services, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1. $29.95. ISBN 0-88868-075-9.

Empowering Women Alcoholics to Help Themselves and Their Sisters in the Workplace — Milstead, Robin J. Kendall/Hunt, Dubuque, 1981. Women and alcoholism; working women and occupational programming; self-help approach to sobriety; the EMPOWER program. Appendix, bibliography. 191 p. Kendall/Hunt Publishing Company, 2460 Kerper Blvd, Dubuque, Iowa 52001. $10.50. ISBN 0-8403-2577-0.

Psychiatric Patient Rights and Patient Advocacy: Issues and Evidence — Bloom, Bernard L. and Asher, Shirley J. (eds). Human Sciences Press, New York, 1982. Historical and conceptual appreciation; stigma of parenthood; insanity plea; antisocial behavior of discharged mental patients; attitudes toward patient rights. Index. 287 p. Human Sciences Press, 72 5th Ave, NY, NY 10011. $29.95. ISBN 0-89885-056-8.

Psychiatric Illness in Physicians — Shortt, Samuel E.D. (ed). Charles C. Thomas, Springfield, 1982. Incidence in relation to sex and field of practice; alcoholism among male doctors in Scotland; alcoholic physicians; narcotics addiction in physicians; physicians' use of mood-altering drugs; marital discord; suicide; stress; personality; hospitalization and treatment; prevention. 329 p. Charles C. Thomas, 2600 S 1st St, Springfield, IL 62717. $34.75. ISBN 0-398-04638-7.

Lithium and Animal Behavior — Smith, Donald F. Human Sciences Press, New York, 1982. Vol 2: effects of lithium on invertebrates, fish, mice, birds, rats, rabbits, felines, canines, monkeys. Index, references. 134 p. Human Sciences Press, 72 5th Ave, NY, NY 10011. $16.95. ISBN 0-89885-075-4.

Helping People to Help Themselves: Self-Help and Prevention — Borman, Leonard D; Borck, Leslie E; Hess, Robert; and Pasquale, Frank L. (eds). Haworth Press, New York, 1982. Self-help as a service-delivery strategy; effects of support groups; preventive processes in self-help groups; professional attitudes, awareness and use of self-help groups. 129 p. Haworth Press, 28 E 22nd St, NY, NY 10010. $20. ISBN 0-917724-67-4.

Life Education in the Workplace — Apgar, Kathryn; Riley, Donald P; Eaton, T; and Diskin, Sarah. Family Service Association of America, New York, 1982. How to design, lead, and market employee seminars; the working parent; stress management; communication skills in the workplace and at home; 184 p. Family Service Association of America, 44 E 23rd St, NY, NY 10010. $17.95. ISBN 0-87304-197-6.

Pharmacology and the Nursing Process — Johnson, G.E. and Hannah, Kathryn J. W.B. Saunders, Toronto, 1983. General principles of pharmacology; autonomic nervous system and neuromuscular blocking drugs; cardiovascular pharmacology; pharmacology of the kidney; drugs and the blood; drugs and the gastrointestinal tract; endocrine pharmacology; CNS pharmacology; chemotherapy; drugs and the law. Index. 508 p. W.B. Saunders Company, 1 Goldthorne Ave, Toronto, ON M8Z 5T9. $21.95. ISBN 0-7216-1028-5.

DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

5th Biennial Canadian Conference on Employee Assistance Programmes, Input '83 — Aug 9-12, Toronto, Ontario. Information: Input '83 Headquarters, Professional and Management Development, Humber College, Box 1900, Rexdale, ON M9W 5L7.

Current Issues in Chemical Dependency — Aug 22-24, Winnipeg, Manitoba. Information: Mary Yunyk, Program Secretary, Continuing Education division, Rm 541, University Centre Bldg, University of Manitoba, Winnipeg, MB R3T 2N2.

Alcoholism and the Family Workshop — Sept 15-16, Winnipeg, Manitoba. Information: Norma Huggins, Information Area Manager, Alcoholism Foundation of Manitoba, 1031 Portage Ave, Winnipeg, MB R3G 0R8.

Fundamental Concepts Course in Addictions — Sept 19-22, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, (ARF), 8 May St, Toronto, ON M4W 2Y1.

Royal College of Physicians and Surgeons Annual Meeting — Sept 19-22, Calgary, Alberta. Information: Robert A. Davis, Associate Director, Office of Fellowship Affairs, Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

Chemical Dependency Intervention Course (CDIC) — Sept 19-23, Winnipeg, Manitoba. Information: Norma Huggins, Information Area Manager, Alcoholism Foundation of Manitoba, 1031 Portage Ave, Winnipeg, MB R3G 0R8.

Detox Training Program (Non-Medical) — Sept 19-23, Oct 17-21, Nov 14-18, Toronto, Ontario. Information: Diane Hobbs, Detox and Rehab Programs, ARF, 33 Russell St, Toronto, ON M5S 2S1.

Introductory Addictions Management Course — Sept 26-28, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Alcohol and Drug Abuse Conference — Sept 27-28, Saskatoon, Saskatchewan. Information: CME office, University of Saskatchewan, 408 Ellis Hall, Saskatoon, SK S7N 0W0.

33rd Annual Meeting of the Canadian Psychiatric Association — Sept 28-30, Ottawa, Ontario. Information: Canadian Psychiatric Association, Ste 103, 225 Lisgar, Ottawa, ON K2P 0C6.

Ontario Chapter, College of Family Physicians of Canada 21st Annual Scientific and Business Meeting —Oct 2-5, Toronto, Ontario. Information: Ontario Chapter, College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

Basic Counselling Skills Course — Oct 3-7, Toronto, Ontario. Information: Doreen Ross, School For Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Addictions '83 International — Oct 12-14, Ottawa, Ontario. Information: Mrs C. Cashman, Coordinator, Postgraduate Board, Royal Ottawa Hospital, 1145 Carling Ave, Ottawa, ON K1Z 7K4.

Managing the Information Function — A Joint Annual Conference of Substance Abuse Librarians and Information Specialists, Librarians and Information Specialists in Addictions — Oct 18-21, Toronto, Ontario. Information: Ron Hall, Information and Promotion, ARF, 33 Russell St, Toronto, ON M5S 2S1.

Pharmacology and Drug Abuse Course — Oct 31-Nov 2, Toronto, Ontario. Information: Doreen Ross, School For Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Behavioural Interventions Course — Nov 14-16, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May Street, Toronto, ON M4W 2Y1.

Strategies for Coordinating Community Services Workshop — Nov 21-23, Toronto, Ontario. Information: Doreen Ross, School For Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Group Therapy Course — Jan 9-13, 1984, Toronto, Ontario. Information: Doreen Ross, School For Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Fundamental Concepts Course in Addictions — Jan 16-19, 1984, Toronto, Ontario. Information: Doreen Ross, School For Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Perspectives on Employee Assistance Programming Course — Jan 23-26, 1984, Toronto, Ontario. Information: Doreen Ross, School For Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Pharmacology and Drug Abuse Course — Feb 6-8, 1984, Toronto, Ontario. Information: Doreen Ross, School For Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Prevention Strategies Workshop — Feb 20-22, 1984, Toronto, Ontario. Information: Doreen Ross, School For Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Workshops 1983-84: Employee Assistance Program Management Update — Feb 22-24, 1984, Toronto, Ontario. Information: Yvonne Johns, department of Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Relaxation and Stress Management Workshop — Mar 1-2, 1984, Toronto, Ontario. Information: Doreen Ross, School For Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

United States

Family Program For Professionals — Aug 15-19, Sept 19-23, Oct 17-21, Nov 28-Dec 2, Center City, Minnesota. Information: Marilyn Brissett, Continuing Education department, Hazelden Foundation, Center City, MN 55012.

Strategic Planning and Marketing for Substance Abuse Services — Aug 16-18, Cambridge, Massachusetts. Information: Management Division, Lesley College Graduate School, 1627 Massachusetts Ave, Cambridge, MA 02138.

Prevention-Outlook for the '80s — Aug 18-20, Myrtle Beach, South Carolina. Information: Cathy McKinney, Charlotte Drug Education Center, 1416 E Morehead St, Charlotte, North Carolina 28204.

1983 Conference on Cocaine — Aug 21-23, Atlanta, Georgia. Information: Peachford Hospital, c/o Charter Medical Corporation, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, GA 30342.

Prevention Skills For Religious Organizations — Aug 22-23, Center City, Minnesota. Information: Marilyn Brissett, Continuing Education department, Hazelden Foundation, Center City, MN 55012.

Alcohol and Drug Problems Association of North America 34th Annual Meeting — Aug 28-Sept 1, Washington, DC. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

7th Annual Summer Institute on Drug Dependence — Aug 28-Sept 2, Colorado Springs, Colorado. Information: Dan Barmettler, Institute for Integral Development, PO Box 2172, Colorado Springs, CO 80901.

Alcohol/Drug Counseling Skills II — Aug 29-Sept 2, Center City, Minnesota. Information: Marilyn Brissett, Continuing Education department, Hazelden Foundation, Center City, MN 55012.

International Lawyers in Alcoholics Anonymous (ILAA) — Sept 9-11, New York City, New York. Information: ILAA Convention Chairman, Keegan, Keegan and Hecker, 202 Mamaroneck Ave, White Plains, NY 10601.

Training Program For Alcoholism Counseling — Sept 10, 1983-Jan 21, 1984, Jan 31-June 2, 1984, Amityville, New York. Information: The Institute of Alcohol Studies at South Oaks, PO Box 426, Amityville, NY 11701.

Training School on Alcohol and Drug Abuse — Sept 12-30, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

Drug and Alcohol Issues Symposium — Sept 14-16, Dayton, Ohio. Information: Thomas Prugh, WORAC, 379 W First St, Ste 300, Dayton, OH 45402.

Drugs in the Workplace: "A Man-Made Disaster." — Sept 19-20, Alexandria, Virginia. Information: Lee Dogoloff, American Council for Drug Education, 6193 Executive Blvd, Rockville, Maryland 20852.

Student Assistance Programming — Sept 19-23, Milwaukee, WI. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Alcoholism: Etiology, Diagnosis and Treatment — Sept 23, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Student Assistance Program — Sept 26-27, Center City, Minnesota. Information: Marilyn Brissett, Continuing Education department, Hazelden Foundation, Center City, MN 55012.

2nd Annual Conference of the National Federation of Parents for Drug-Free Youth — Sept 26-28, Washington, DC. Information: National Federation of Parents for Drug-Free Youth, 1820 Franwall Ave, Ste 16, Silver Spring, Maryland 20902.

National Youth Workers Conference — Sept 26-29, Chicago, Illinois. Information: The National Youth Work Alliance, 1346 Connecticut Avenue, NW, Washington, DC 20036.

Health and Addictions Conference — Sept 29-Oct 3, New York, New York. Information: Dan Barmettler, Institute for Integral Development, PO Box 2172-L, Colorado Springs, Colorado 80901.

American Association for Automotive Medicine 27th Annual Conference — Oct 3-5, San Antonio, Texas. Information: American Association for Automotive Medicine, 40 2nd Ave, Arlington Heights, Illinois 60005.

12th Annual Meeting of the Association of Labor Management Administrators and Consultants on Alcoholism — Oct 3-7, Minneapolis, Minnesota. Information: ALMACA, 1800 N Kent St, Ste 907, Rosslyn, VA 22209.

Treating Cocaine Dependence — Oct 6-7, San Francisco, California. Information: Lee Dogoloff, American Council for Drug Education, 6193 Executive Blvd, Rockville, Maryland 20852, or Joan Zweben, Pacific Institute for Clinical Training, Education and Consultation, 714 Spruce St, Berkeley, CA 94707.

Basic Drug Information for Alcohol/Drug Counselors — Oct 10, Indianapolis, Indiana. Information: Kay Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Working With Children of Alcoholics — Oct 19-21, Milwaukee, WI. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

3rd Annual Primary Prevention Conference "Kid's Stuff II" — Nov 1-3, Austin, Texas. Information: Peggy Frias-Lynch Prevention Services, Texas Commission on Alcoholism, 201 E 14th St, 8th floor, Austin, TX 78701.

Innovations in Alcohol/Drug Abuse Programming: Models-Methods-Evaluation — Nov 7-11, Pacific Grove, California. Information: Leslie Nyberg, Evaluation and Research department, Box 11, Center City, Minnesota 55012.

American Society of Criminology 35th Annual Meeting — Nov 9-12, Denver, Colorado. Information: Joseph E. Scott, department of Sociology, Ohio State University, Columbus, Ohio 43210.

ADPA 1983 Western Regional Conference — Nov 13-16, Los Angeles, California. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

Mental Health Section and Forum on Drug and Alcohol Problems, of the American Public Health Association, Annual Meeting — Nov 13-17, Dallas, Texas. Information: Dr David Duncan, Mental Health Membership Chairman, SIU Department of Health and Education, Carbondale, IL 62901.

Issues of Sexuality in Alcohol/Drug Dependency Counseling — Nov 17-19, Center City, Minnesota. Information: Marilyn Brissett, Continuing Education department, Hazelden Foundation, Center City, MN 55012.

2nd Annual National Conference on Alcoholism and the Family, Western Edition — Nov 20-23, San Diego, California. Information: FamCon West II, PO Box C 19051, Seattle, Washington 98109.

The Third Annual New England Conference on Alcohol Issues, "Trends in Policy and Planning for Alcohol Issues" — Nov 30-Dec 2, Newport, Rhode Island. Information: New England Conference on Alcohol Issues, 755 Boylston St, Ste 306, Boston, MA 02116.

SECAD/8, Southeastern Conference on Alcohol and Drug Abuse — Nov 30-Dec 4, Atlanta, Georgia. Information: Barbara D. Turner, Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, GA 30342.

Abroad

Middle Eastern Summer Institute on Drug Use (MESIDU): Techniques, Strategies, Concepts and Options — Sept, Jerusalem, Israel. Information: Stan Einstein, PhD, Director, MESIDU, 113/41 East Talpiot, Jerusalem, Israel.

International Conference on Alcoholism — Sept 26-30, Reykjavik, Iceland. Information: International Council on Alcohol and Addictions (ICAA), Case postale 140, 1001 Lausanne, Switzerland.

International Association for Accident and Traffic Medicine (IAATM), 9th International Conference — Sept 27-30, Mexico City, Mexico. Information: Rune Andreasson, Executive Director, IAATM, Karlavagan 119, PO Box 10043, S-100 55, Stockholm, Sweden.

13th International Institute on the Prevention and Treatment of Drug Dependence — Oct 10-14, Oslo, Norway. Information: ICAA, Case postale 140, 1001 Lausanne, Switzerland.

Currents in Alcohol Research and the Prevention of Alcohol Problems — Nov 7-9, Lausanne, Switzerland. Information: Swiss Institute for the Prevention of Alcohol Problems — (SFA/ISPA), PO Box 1063, CH-1001 Lausanne, Switzerland.

9th International Conference on Alcohol, Drugs and Traffic Safety — Nov 13-18, San Juan, Puerto Rico. Information: T-83 Secretariat, GPO Box 5067, Medical Sciences Campus, San Juan, Puerto Rico 00936.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

2nd International Congress on Drugs and Alcohol — Dec 18-22, Tel Aviv, Israel. Information: Congress Secretariat: Peltours Ltd, Congress department, PO Box 394, Tel Aviv, 61003 Israel.

An International Conference on Alcoholism and Drug Addiction — Apr 2-7, 1984, Canterbury, England. Information: Conference Secretary, Broadway Lodge, Oldmixon Rd, Weston-super-Mare, Avon, BS24 9NN, England.

4th World Congress of Alternative Medicine — July 13-15, 1984, Amsterdam, Netherlands. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

History — a resource policy makers neglect

By Lynn Payer

NEW YORK, NY — In 1776, Benjamin Rush signed the United States' Declaration of Independence. Eight years later, he published An Inquiry into the Effects of Ardent Spirits on the Human Mind and Body, *in which he elaborated a disease concept of alcoholism.*

The case of Dr Rush is only one of the many instances treated by Mark Edward Lender, PhD, and James Kirby Martin, PhD, in their book Drinking in America, *in which seemingly modern concepts turn out to be not so modern.*

Colonial US residents, for example, did not consider alcohol itself evil, but nevertheless had laws regulating what tavern owners could sell, to whom, when, and even at what price. The Washingtonian Movement of the 1840s sounds very much like the present day Alcoholics Anonymous. And the colony of Massachusetts, which ordered one Robert Cole to wear a scarlet "D" for drunkard, is echoed now in legislation before the New York state legislature calling for red letter licence plates for convicted drunk drivers.

"One of the problems with a good deal of the alcohol research," Dr Lender, a visiting professor at the Rutgers University Center of Alcohol Studies, New Brunswick, NJ, told **The Journal**, *"is that it's approached in an historical void. Most workers know so little about the early attempts to deal with drinking, and it's too often told in terms of stereotypes."*

Drs Lender and Martin are believers in "a useful past," and they would like to give back modern alcoholism research and treatment its history.

But, more than that, they demonstrate it was not such a strange coincidence that a statesman like Dr Rush would also be a pivotal figure in the movement to control drinking; alcohol policy in the US has always reflected the broader social movements of the times. The colonials drank in a European style; the republicans began to see alcohol as a substance that threatened the kind of citizenry needed to build a republic.

Prohibition was the logical outgrowth of the reform movements of the late 1900s, and its demise may have been more a result of growing social pluralism than of the fact it was a bad idea.

In reality, said Dr Lender, "you cannot separate alcohol policy from the mainstream of American history."

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Colonial Americans drank like Englishmen and women. Although most drank beer, they drank it seriously. While precise consumption figures are lacking, estimates show that by the 1790s, those over 15 years drank an average of just under six gallons of absolute alcohol each year, in contrast to less than 2.9 gallons per capita today.

But while colonists were heavy drinkers, they were not, in general, problem drinkers. Much of the drinking was family- and community-oriented. "Most colonials willingly conformed to community values, and if some refused to do so voluntarily, the majority accepted the community's right to compel prescribed behavior.

While penalties for individual drinkers could be severe, Puritan churches were consistently forgiving; if the drunkard repented, he was restored to church membership. In Virginia, magistrates worried not about drinking but rather about drunkenness and its effect on community stability. Even drunken women were acquitted if their crime was nothing more than drunkenness.

"It is very important to recognize that colonial magistrates, in both the North and the South, rarely let concerns about excesses in drinking spill over into attacks on the consumption of alcoholic beverages in general . . . . If people denounced cases of individual intemperance, they did not directly intimate that the fault lay in liquor itself; the problem was one of isolated deviants misusing what society viewed as a wholesome, healthful, and even necessary product."

Prohibitionists: they promised everything and couldn't deliver

Concerns surface

But beer was giving way to distilled spirits, partly because spirits were easier to transport. As the colonial period drew to a close, the first attacks on liquor as a substance began to be made, although the attack was against hard liquor.

The American Revolution heightened the anti-liquor sentiment.

"Americans going through the revolution asked themselves 'What is a republic?' 'What is an ideal republic?' and they came to the conclusion that citizens must be virtuous. Concerns with drinking surfaced at the same time with that of norms of the good republic," said Dr Martin, professor of history at the University of Houston, and a specialist in the social history of the American Revolution.

Perhaps, he suggested, the absence of such a revolution in Canada may account for prohibition never having become a significant issue there. "Canadians had more confidence about themselves. They didn't have the same process of working out the idea of the 'good citizen.' "

Temperance movement

But while the concern was increasing, so was the drinking. "In fact, the period from the 1790s to the early 1830s was probably the heaviest-drinking era in the nation's history," say the authors. "Consumption estimates tell the story dramatically. From an annual average of 5.8 gallons of absolute alcohol per capita in 1790, mean absolute alcohol intake rose to 7.1 gallons a year by 1810 and, with minor fluctuations, remained at about that level until at least 1830."

By 1840, that had fallen to slightly more than three gallons, the steepest drop in US history.

The explanation for the drop was, apparently, the development of a broad-based temperance movement. By 1835, temperance organizations counted 1.5 million members, with thousands of other citizens reducing their consumption of alcohol.

The pre-Civil War temperance movement, say Drs Lender and Martin, was again part of a broader phenomenon. "Any condition or situation labelled evil generated an effort —and frequently a formally organized national society — to set it right.

"Temperance was only one facet of this general phenomenon: Peace, abolition, the elimination of profanity and Sabbath-breaking, women's rights, mental health, the rekindling of orthodox Protestantism, concern over immigration, education, and other causes all attracted champions."

In the 1840s, the Washingtonian Movement swept the nation. The movement was founded by six Baltimore drinkers. It emphasized saving individual alcoholics, not general social reform.

"Members worked fervently to hold one another to the pledge. They rushed to the aid of those who relapsed. If necessary, they helped fellow members find new jobs or temporary financial support. This work with the alcoholic was critical in the Washingtonian view; for beyond taking the pledge, the society stressed that the lifestyle of drunkards had to change. If they were to lose forever their passion for liquor, they had to avoid the social situations that had led them to drink in the first place." Under the Washingtonians' guidance, perhaps 600,000 alcoholics recovered by the late 1840s, of which about 150,000 ultimately remained abstinent.

The movement was short-lived, however, in part because the established churches, which had been allies, had come to resent Washingtonian opposition to their presumed leadership of the drug struggle. But the Washingtonians left a legacy of proliferating fraternal temperance orders.

By 1850, consumption dropped to 2.10 gallons of absolute alcohol per person, a level around which it hovered until the imposition of national prohibition.

"The national binge had ended before the Civil War, and postwar assaults on alcohol generally came not against drinking patterns or consumption rates *per se*, but against drinking as a symbol of rampant pluralism, individualism, and potential social disorder."

Cleansing the evil

Society had to be cleansed of the unquestionably evil substance that alcohol was now seen as, but the reform movements of the time tended not to blame the individual drinker.

By the early 1900s, most US citizens genuinely considered prohibition the issue of the day. "If they were not thoroughly committed temperance workers themselves, they were at least willing to give the sober republic a fair try."

When the prohibition amendment was sent to the states for ratification, no previous amendment had ever passed so quickly and with so clear a mandate.

Prohibition oversold

Why then was the amendment almost as unanimously repealed 13 years later, bringing down with it not only national prohibition, but the entire temperance movement?

One reason, says Dr Martin, is that the prohibitionists oversold their program.

"They had promised prohibition would end poverty, vice, crime, and political corruption, and they couldn't deliver everything. They promised the same social Nirvana that the revolution had promised —in fact, prohibition was seen as part of the continuing American Revolution. Prohibition was going to be the final value."

Another reason is that the victorious prohibitionists began to display a meanness of spirit that blamed not just the drink but also the drinker. Certain prohibition leaders, for example, continued to insist that the government maintain the practice of adding denaturants to industrial alcohol, despite protests that poorly-washed moonshine was killing or blinding scores of Americans.

The temperance movement's final break with the majority of Americans, the authors say, came with the passage of the Jones Act in March, 1929. This tightened the provisions of the Volstead Act (the legislation dictating how the prohibition amendment would be enforced) to provide for first offence jailings of five years *and* a fine of $10,000.

Dr Martin believes, in fact, that had the prohibitionists not moved so far out of line with the rest of the nation, temperance might be a stronger force in the United States today, as it has remained in Scandinavia.

Emerging pluralism

But larger social forces were acting upon the nation that may ultimately have been responsible for the decline of public support of prohibition. A pluralist culture was dawning that shifted the country away from the neo-republican reform goals to one of increasing tolerance for individual freedom.

"From the New Deal on, those with political power would applaud (and play to), rather than fight, the pluralism denoting national life. Not surprisingly, organizations and ideologies in conflict with the new reality, a position the dying temperance movement epitomized, now were doomed to minority and splinter group status."

That emerging pluralism, say the authors, has left the US with a legacy of ambivalence about drinking and other problems. The result has been a hodge-podge approach to alcohol and to drinking, with each state and even each locality within a state determining its own policy.

The view that alcohol policy must be seen in the total societal context does not promise easy solutions to the problems of alcohol abuse and its consequences, such as drunk driving.

"Planning significant modifications in (US) drinking habits is a formidable task. That any group of policymakers could even agree on new standards of drinking behavior is itself doubtful. And, if they could, building popular acceptance of the norms would be another affair entirely. In the historical instances in which behavioral norms acted to check drinking excesses, alcohol use was in a healthy balance with other societal mores and traditions. Drinking behavior, in short, was intertwined with a coherent system of generally stable and accepted cultural norms. But modern America has lacked precisely this context of uniform values for generations."

Dr Lender: "There's no consensus on fundamental issues — and drinking is pretty fundamental."

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Drinking in America, by Mark Edward Lender and James Kirby Martin, The Free Press, A Division of Macmillan Publishing Co, 866 Third Ave, New York, NY 10022.

THE BACK PAGE

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The Journal

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Days of leadership by a 'top few' are gone

US workers must build policy consensus

By Anne MacLennan

RACINE, WISC — Alcohol and drug abuse professionals in the United States must stop looking to Washington for leadership, decide what they stand for, and communicate that through state legislatures to Congress for translation into law.

The days of policy development by a few top professionals are past, said William Mayer, MD, in one of his last official appearances as acting director for two years of the US National Institute on Alcohol Abuse and Alcoholism (NIAAA). The new director is Robert Niven, MD. (See page 4.)

"That's a little lesson in civics brought home to me very dramatically in the couple of years I've been in Washington," said Dr Mayer, administrator of the US Public Health Service's Alcohol, Drug Abuse and Mental Health Administration. It is the umbrella body of three institutes: the NIAAA, the National Institute on Drug Abuse, and the National Institute of Mental Health.

Mayer: warning

He said it's no longer possible or appropriate for the "private preoccupations" of staff of institutes to get into the pamphlets and literature or be communicated to friendly staff members of congressmen, or senators, who make the laws.

"Policy has to come out of groups like this," he told the 1st National Invitational Policy Forum on Alcohol and Other Drug Problems — a think tank of about 40 leaders in the US alcohol and drug field — held here in late July. Participants represented private and public sectors; prevention and treatment programs; local, state, and federal governments and associations; and the alcohol beverage industry.

Calling on leaders of organizations and associations across the country that "still have some respectability and some voice and some ability to represent collections of people" to work together, he singled out the beverage industry for a particular warning.

"More than ever before, it is in the interests of the people in the alcohol beverage industry to get together with the rest of the field . . . and to do it so that your getting together doesn't appear to subborn the loyalties of people in the field.

"The massive uprising occurring in this country among teenagers and among parents' groups is going to push you farther and faster toward some kinds of probably very unrealistic controls and punitive reactions to alcohol and drug abuse that most of us who are professionals in the field feel are not only non-productive but counterproductive."

He allowed that policy issues are complex. "I think there is probably no more complex topic in health and social services systems today."

(See — Community — page 2)

Stronger inter-group cooperation goal of new ADPA president

By Anne MacLennan

RACINE, WISC — Tackling charges that the alcohol and drug abuse field in the United States is fragmented and in disarray will be among the priorities of the new chief of the Alcohol and Drug Problems Association of North America (ADPA).

Larry Monson, a social worker, and director of the Wisconsin State Office of Alcohol and Other Drug Abuse, was scheduled to be named president at the annual meeting of the ADPA in Washington at the end of August. He succeeds Kay Hardin of Texas.

He told **The Journal**: "One of the priorities over the next couple of years will be to focus on building much stronger working relationships with other national associations and alcohol- and drug-related interest groups.

"This will enable us to overcome the criticism that we are not a united field, that we are divided and fragmented, and that we don't have a constituency, a voice, in this country or in the alcohol and drug field."

He said there has been a void in the field in the US over the last three or four years in terms of policy formulation at the state and federal levels and in the public and private sectors.

Many people in the field believe there's been an erosion in the relationship between the executive and administrative branches of government and the leadership in the field, and that leaders are less and less called upon for input into policy and program legislation, he said.

"We want input up-front, on a proactive rather than a reactive basis, input from the leadership in the field at all levels — national, state, and local.

Does the US administration, and particularly Carlton Turner, PhD, chief of the White House Office on Drug Abuse Policy, want it that way?

"I'm not sure at this point. Until I've had an opportunity to talk with him and others, I'm not willing to say.

"But, if they don't accept it, we will become prepared to advocate and lobby within Congress for our points of view and our policy recommendations and to indicate to Congress that they are not working with us, that their policies and recommendations are not relevant, if that indeed is the case.

"I think you're going to see the field unite in terms of the parent movement, minorities, the traditional alcohol/drug associations, and come out with one voice demanding that our advice, our knowledge be sought at the development stage, the thought stage, rather than at the response stage."

(See — Monson — page 2)

Monson: we'll lobby Congress

Northern school-kids: special programs must be created for them

Native children smoke most, problem's worsening: study

By Maureen Brosnahan

WINNIPEG — The results of one of the first studies ever of the smoking habits of Native people has found smoking rates of Northwest Territories (NWT) children to be among the highest of any school population in Canada.

The soon-to-be-published study reveals that 49% of boys and 53% of girls in the schools are regular smokers. That compares to the nation-wide figure for Canada from the World Health Organization showing only 35% of boys and 41% of girls are regular smokers.

"The statistics are alarming and there has to be more work done on this," said Kane Tologanak, NWT health minister. The study was undertaken by his department and Health and Welfare Canada last winter.

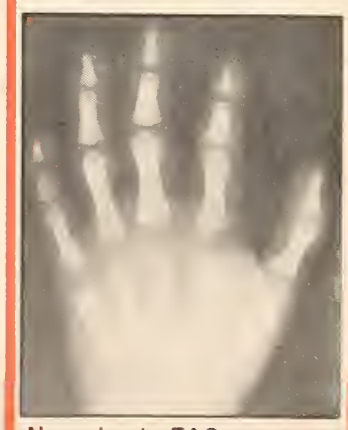
He said students in 66 of the 70 NWT schools were examined, and that the study yielded a 94% response rate. "It confirmed the problem does exist and that it's getting worse."

Mr Tologanak said smoking education programs geared to the Native population need to be introduced in schools. He said the NWT is supporting the federal government's new, nationwide, anti-smoking campaign, the Generation of Non-Smokers, (**The Journal** May, 1982), but programs designed specifically for children in the north must be created.

The study also showed peer pressure plays an important role in students' smoking habits. Between 10 and 14 years of age, students with friends who smoke were 19 times more likely to be smokers themselves than those with friends who didn't smoke.

(See — Hardships — page 2)

INSIDE



NEWS

Briefly . . .

Let that be a lesson

ANDERSON, IND — Instead of giving a drunk driver a nine-year prison sentence for killing a young co-ed, a judge here ordered the man to lecture to civic groups and donate 10% of his income for the next two years to Mothers Against Drunk Drivers (MADD) as part of his punishment. He was also placed on probation for five years. Judge Thomas Newman Jr described the 33-year-old accused man as a "young, articulate college graduate" who "has the potential to help other people" avoid making the same mistakes.

Thirst excels supply

PEKING — As summer temperatures soared in this densely-populated Chinese capital, more and more workers were saying: 'Make it a Wuxung.' And that's been causing headaches for China's three state-run breweries — Wuxung, Peking, and Yanjin. They're striving to meet higher production quotas in response to growing consumer demand for beer. Chinese officials estimate public thirst for suds outstrips total beer production two-to-one. Availability is further restricted by corrupt officials, who siphon off 20% of the beer produced for resale on the black market, *The Globe and Mail* reports.

Scots target sniffers

LONDON — A dramatic increase in glue-sniffing has prompted Scottish authorities to introduce the Solvent Abuse Act, empowering a children's panel (Scotland's alternative to juvenile court) to order compulsory care for young solvent abusers. The Scottish Office reports that police files show an increase in glue-sniffing cases — to 3,300 in 1981 from 2,240 in 1979. Deaths caused by glue-sniffing rose to 14 in 1982 from only one in 1976. The legislation has not spawned imitators in England and Wales, where, says *The Sunday Times*, authorities consider "education and encouragement" preferable to court action.

Mistaken identity

IBIZIA — A brawl at a Spanish hotel has raised questions about drinks with look-alike labels. A vacationing British couple took exception to a Bacardi-size bill after an evening of imbibing drinks allegedly containing its cheaper imitator, Bacaly. In the ensuing melee, the British housewife scored with a punch to the eye of the house bartender. Undaunted by a subsequent trip to the local police station, the woman had the Bacaly analyzed by a Home Office expert upon her return home. Results confirmed Bacaly contained less alcohol than Bacardi. "It gave some people headaches and it didn't even smell like it should," she complained to *The Sunday Times*.

Boost drinking age

TORONTO — Alaska and Delaware are the latest of the United States to boost the drinking age to 21, bringing the number (including the District of Columbia) to 27. The legal age is 19 in 13 states, 20 in six others. Only four states permit the sale of alcohol to 18-year-olds.

Competing for limited resources

Health promo trend threatens EAPs

By Gary Lamphier

TORONTO — The trend toward health promotion programs represents a threat to the future of employee assistance programs (EAPs), says the national adviser to the federal government's EAP.

"Because so many groups are competing for the same dollar, a lot of EAP people are saying we've got to broaden our scope to encompass other functions, like stress management," said Wayne Corneil, national adviser, EAP, Medical Services Branch, Health and Welfare Canada. "But you can't be all things to all people. It diffuses the service EAPs are set up to give."

Mr Corneil made his remarks during the plenary session of Input '83, the Fifth Biennial Canadian Conference on EAPs and alcohol and addiction problems in the workplace, held here.

Corneil: stress

"Today we're in the business of competing for resources," he said.

Mr Corneil said the availability of funds to EAPs is also threatened by "charlatans" and "snake oil salesmen" who are passing themselves off to upper management as employee health experts.

"No matter what problem you have, (they say) it must be stress induced," said Mr Corneil, adding that management has become increasingly skeptical of health promotion proponents and their programs.

"This is not to suggest that there are not reputable, good programs out there. But as the real estate salesman said when I bought my house, 'May the buyer beware.'"

INPUT '83

More next month

Mr Corneil told **The Journal** that funds are being diverted to stress management and other health promotion programs when the money could be better spent on alcohol abuse problems in the workplace. He said professionals in the EAP field are shifting their focus away from alcohol, though many "wouldn't know an alcoholic if they fell over one."

Hardships compound risk to Native smokers

(from page 1)

As well, 17% of the Indian children, 11% of the Inuit children, and 2% of the non-Native children used snuff. Seventeen per cent of the overall population reported using chewing tobacco.

Margaret Thomson, a nurse with the Manitoba Lung Association who has worked in Northern Canada, said statistics indicating the high incidence of smoking among Native people across Canada, while scanty, "are really quite alarming."

She said in view of the poor living conditions, overcrowding, lack of sanitation, and other health problems which are common in many Native communities, the risks associated with smoking are only increased.

"We need more information about the smoking habits of Native people," she said. "As far as I can ascertain, there are no smoking programs for Native people," although she said some have been promised.

Mr Tologanak and Ms Thomson were addressing a session on smoking and minority groups at the Fifth World Conference on Smoking and Health held here recently.

Other delegates from the United States, New Zealand, and Australia also reported a high incidence of smoking among minority groups in their countries.

In the case of the Maori people of New Zealand, delegates were told 54% of the male and 58% of the female population were reported to be regular smokers. As well, the incidence of lung cancer among the Maori was 81 cases per 100,000 for men, and 45 per 100,000 among women. That compares to 47 (males) and 11 (females) per 100,000 in the general population.

"It seems to me," Mr Tologanak said, "that the cigarette has taken over the world. It's time some action was taken.

"I think we do have a problem and we owe it to our generations coming to put out that old cigarette."

In another presentation, Richard Stanwick, MD, assistant professor of pediatrics at the University of Manitoba's medical school, gave the results of a study he conducted on smoking patterns in students in Thunder Bay, Ont. He found that of 947 students who responded to the questionnaire in one high school, 38% of the boys had never tried smoking compared to only 25% of the girls.

"Girls are experimenting more than boys with cigarettes." Dr Stanwick added that he found girls were more likely to start smoking if their mothers smoked.

Dr Stanwick said boys are more likely not to smoke because of positive role models such as "a clean living fellow who sells jeans whose name is Wayne Gretzky."

Girls don't have a similar model, and "cigarettes are associated with the liberated woman," he said.

Young girls: they lack a positive role model

Community support 'disgraceful'

(from page 1)

And they have to be resolved in the face of "far less — absolutely, disgracefully less — support from the community at large than a broad range of other health areas." He referred among others to cancer, heart disease, stroke, arthritis, rheumatism, children's disorders, and maternal and child health.

"You name it. We have the least support from around the country of any health enterprise. And we have the most questions asked about whether we even are a health enterprise," Dr Mayer said.

However, he said, the issues that need to be addressed "from my point of view are much the same as they have been for some years now.

"They are issues to do with health insurance; issues of so-called responsible drinking, a term I don't like; issues of controlled drinking, of location of treatment and who should get it; issues having to do with advertising and free speech; issues that can be considered ethical, legal issues.

"Are we exploiting Medicare patients by readmitting and readmitting them at extremely high cost to give certain very specific kinds of treatment? What is appropriate treatment?

"Can we afford, as a society, to treat alcoholism, other than the very serious physical problems, in hospitals designed to treat physical diseases at 400 bucks a day?"

These are the questions and the issues "that are going to have to be resolved, and they can only be resolved by the people in the field, speaking with some clarity of vision and some purpose."

As for the Public Health Service, its primary mission is research, Dr Mayer said.

It and the institutes are "not in the business of generating policy positions for the government.

"We are very clearly charged," he said, with getting people together and with collecting information and scientific data upon which policy can be based.

Monson favors continent-wide info exchange

(from page 1)

Mr Monson said in addition to national and state leadership, three other issues are of immediate concern — prevention, funding, and controls.

To facilitate broad exchange of views, he would like to revive the idea of large North American meetings every year or two that draw together people not only from across the US but also from Canada and, possibly, Mexico.

Mr Monson was one of about 40 leaders in the field across the US who attended the 1st National Invitational Policy Forum on Alcohol and Other Drug Problems held here in late July.

Participants represented private, public, treatment, and prevention sectors, and local, state, and national bodies. Discussion centred on policy issues.

Influx of cheap, pure heroin puts new pressures on US

By Harvey McConnell

WASHINGTON — A rise in heroin-related hospital admissions and overdose deaths across the United States is being attributed to cheaper and purer supplies on the streets and increased use of heroin by middle-class cocaine abusers.

Figures compiled by the US Drug Abuse Warning Network (DAWN) of the National Institute on Drug Abuse show heroin overdose deaths rose from 474 in 1980, to 601 in 1981, and 771 in 1982.

Hospital emergency-room admissions related to heroin reported by the DAWN rose from 7,784 in 1980, to 9,271 in 1981, and 11,538 in 1982.

Average price for 1 mg of heroin has dropped to $2.22 today from $2.34 in 1980, and average purity has risen to 5.6% from 4% over the same period, says the US Drug Enforcement Administration (DEA).

Although the majority of heroin users live in poor, inner-city areas, a rising number of middle-class men and women are becoming hooked on the drug because they use it to moderate the crash from a cocaine high.

More than 50% of the heroin entering the US comes from the Southwest Asian countries of Iran, Afghanistan, and Pakistan, and is dominant in the eastern part of the US. Some 36% is smuggled from Mexico and is dominant in the midwest and west, and 10% comes from the Golden Triangle countries of Thailand, Burma, and Laos and is dominant in the west.

The immediate future does not augur well, according to DEA estimates.

Southwest Asian producers have ample supplies of opium stockpiled. There is little chance of suppression in Iran because of its political instability and in Afghanistan because of the Soviet invasion.

The Pakistan government has difficulty at the best of times in trying to control the fierce Pathan tribesmen in the Northwest Frontier Province who cultivate the opium poppy. At present the government does not want to antagonize them unduly because of the Soviet presence in neighboring Afghanistan.

Mexico's current economic problems may tempt more people to risk growing the opium poppy and smuggling heroin into the US despite government eradication programs.

In the Golden Triangle there have been record harvests. Supplies are plentiful even with several major suppression operations by the Thai government against the Shan United Army which controls drug trafficking on the Thailand-Burma border.

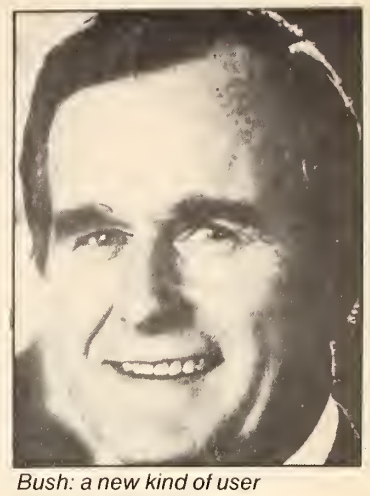
The rise in heroin availability is a major target of the National Narcotics Border Interdiction System created by US President Ronald Reagan. The inter-agency cooperative effort is directed by Vice-President George Bush, who headed the widely-publicized South Florida task force against drug smuggling from South America. (**The Journal**, Oct, July, April, 1982).

Regional offices of the new national network have been set up in New York, Chicago, New Orleans, El Paso, Miami, and Long Beach, Cal. The network will ferret out information about US-bound shipments from Central Intelligence Agency agents abroad, and from the US military, Coast Guard, Customs Service, the DEA, and the Federal Bureau of Investigation.

In one of its first operations, the network has arrested a US Army chief warrant officer only a month away from retirement, his Thai-born wife, and four other Thai nationals for smuggling 90% pure heroin into the Washington and Los Angeles areas.

Meanwhile, the influx of cheaper and purer heroin is being seen in Washington, DC. The US capital is suffering from the worst outbreak of heroin use since the early 1970s. There were 133 heroin overdose deaths in the city in 1982, and 865 heroin-related, hospital emergency room admissions.

However, a study for the city government by the US Centers for Disease Control has found that many of the overdose deaths are not of hard-core addicts but of people in their early 30s lured by lower prices and higher purity into "chipping," or using heroin for recreation on sporadic occasions.



Bush: a new kind of user

In the past two years there has been a tremendous increase in police activity, ranging from the "jump out" squads which nab dealers on the streets, (**The Journal**, March) to undercover agents posing as sellers. The result is that in 1982 police arrested 6,500 people on drug charges, or 26% of all arrests made in Washington.

City judges and prosecutors are complaining about the number of drug-related cases scheduled to be tried, and officials estimate that about 75% of the inmates in the city jails are drug abusers.

Ironically, the crime rate in Washington dropped by 11% in 1982. Police officials said this is partly due to a decrease in the price of heroin, which means addicts have to steal less to pay for their supply.

Treatment resource audit shows high utilization

WASHINGTON — A biennial survey of drug and alcohol treatment resources has found that on Sept 30, 1982, the United States had the capacity to treat 345,215 alcohol abusers and 196,289 drug abusers.

The figures were tabulated from more than 90% of known treatment units in the US which reported to the survey conducted by the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse.

Utilization of these resources on that day ran at 84.3% of capacity for alcohol abuse and 88.3% for drug abuse, among 2,729 alcohol abuse treatment units, 1,514 drug abuse units, and 1,504 polydrug abuse units.

What effects federal budget cuts and the advent of block grants have had will not be known until another survey is done in 1984.

Impressively similar to stateside counterparts

Children of military carry drug habits abroad

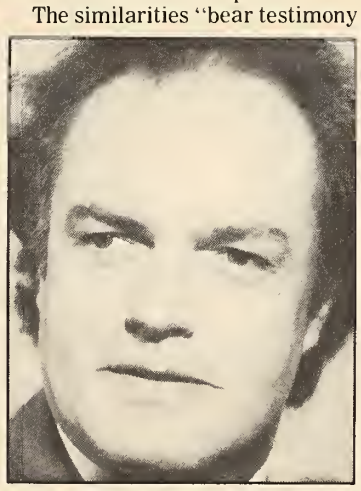
By Harvey McConnell

WASHINGTON — High school students attending United States military schools abroad carry their stateside drug habits with them, a joint study for the US National Institute on Drug Abuse (NIDA) and Department of Defense (DOD) reveals.

A study of 2,400 seniors in 33 DOD schools abroad was carried out by Lloyd Johnston, PhD, and colleagues from the University of Michigan. It is similar to the annual survey of 18,000 US seniors in 142 schools Dr Johnston does for the NIDA (**The Journal**, April).

Although there are variations among the two groups, Dr Johnston concludes that the patterns of the overseas students "are impressively similar to those of their stateside counterparts."

The similarities "bear testimony to the degree to which the dependents of American military overseas carry the cultural habits of their society with them, since these drug usage rates very likely contrast sharply to those in surrounding communities overseas."



Johnston: cultural habits

Highest rate of illicit drug use was reported by 59% of the high school seniors in North Germany, followed by 56% in the Mediterranean region, 53% in South Germany, 45% in the Pacific and Atlantic regions, and 38% in the Panama region.

Dr Johnston finds that fewer of the seniors abroad use cocaine, amphetamines, nitrite inhalants, and methaqualone than their counterparts in the US, but more use other inhalants, tranquillizers, barbiturates, heroin, and other opiates.

Availability is a major factor: tranquillizers, heroin, and other opiates are more readily obtained abroad.

Overall, the study finds that 64% of both US and overseas students have tried an illicit drug, and approximately 40% have tried an illicit drug other than marijuana. However, daily marijuana smoking is lower among the overseas students (4%) than among those in the US (6.3%).

There are differences in alcohol and tobacco use: daily drinking is reported by 8.5% of the overseas students compared with 5.7% in the US, and daily cigarette smoking is reported by 26% of the overseas students compared with 21% in the US.

Overseas students exhibit somewhat less disapproval of all types of drug use, although they agree with their stateside counterparts about the risks for users of various drugs, with the exception of marijuana and alcohol.

Dr Johnston said a possible explanation is that fewer of the overseas students drive cars, where alcohol and marijuana use could put them at risk, and that students in the US have become more aware of the risks in the past several years.

Both the overseas and US students support laws prohibiting drug use, although more overseas students were tolerant of smoking marijuana in private and getting drunk in private.

Dr Johnston found that in both groups there is less drug use of any kind among students who plan to attend college.

Like far out — a checklist for the new revival

By Wayne Howell

According to Alan Furst, writing in the August issue of *Esquire* magazine, we are in for a 60s revival. Furst's antennae were set a-quivering by the recent publication of three books about LSD: a re-issue of *The Psychedelics Encyclopedia*, the appearance of the memoirs of Albert Hofmann, the Swiss chemist who discovered LSD, and the publication of the memoirs of Timothy Leary.

Furst admits he might be a little premature and/or paranoid in predicting a 60s revival, but the idea is really not as preposterous as it might appear. After all, the late 1970s saw a 50s revival in the form of movies such as 'Grease' and music such as 'new-wave' which was nothing more than Bill Haley and the Comets revisited. If the 50s are already grist for the nostalgia mill, can the 60s be far behind?

If a 60s nostalgia-trip is coming we had better get prepared for it. I have compiled a little check-list of things to do in anticipation of a 60s revival. I offer it here as a public service:

1) Practise dressing in an eccentric manner so as to better express your individuality. The best way to do this is to check out what other people around you are wearing and then conform to whatever pattern of eccentricity is prevalent. That's the way it was done in the 60s. But in the 60s it was sometimes difficult to find the proper eccentric gear. That will be no problem in the 80s: if we are going to have a 60s revival there will undoubtedly be Calvin Klein bell-bottoms and Yves St Laurent tie-dye shirts available in the better stores, and knock-down versions of same that you can pick up for a reasonable price at K-mart and Woolco.

2) Buy a T-shirt with a marijuana leaf on it.

3) Re-read all the works of Herbert Marcuse, Carlos Castenada, Aldous Huxley, and Marshall McLuhan. If this sounds like a pretty tall order, forget it. Very few people who talked about those writers in the 60s actually read what they wrote. If you could fake-it in the real 60s you should be able to fake-it just as easily in the 60s revival.

4) Practise talking a lot about drugs. You don't actually have to take them. Just talk about them all the time.

5) Practise expanding your vocabularly in an unintelligible direction. In the 60s clean-shaven explorers of outer space looked back on our planet. Some described it as 'bee-yutiful'. Others saw it as 'byew-tiful'. Others were quite convinced it was 'beautiful.' The astronauts, strange fugitives from the 40s, were intelligible, but not articulate. The hirsute 60s explorers of inner space, on the other hand, were articulate, but not intelligible. They had out-of-mind trips that were 'out of sight.' While their cortical neurons tripped the light fantastic, they had 'heavy' experiences.

If you want to get into the swing of the 60s revival, practise using vague amorphous words, separated with significant pauses fraught with transcendental meaning. (Example: you could rephrase the last sentence like this — 'If the 60s thing is your bag . . . flash on coming off the wall a lot . . . I mean like wordwise . . . dig.') And say 'man' a lot, even if you are talking to a woman. Don't be afraid of leaning on her space; she'll know where your're coming from.

NEWS

Briefly . . .

Let that be a lesson

ANDERSON, IND — Instead of giving a drunk driver a nine-year prison sentence for killing a young co-ed, a judge here ordered the man to lecture to civic groups and donate 10% of his income for the next two years to Mothers Against Drunk Drivers (MADD) as part of his punishment. He was also placed on probation for five years. Judge Thomas Newman Jr described the 33-year-old accused man as a "young, articulate college graduate" who "has the potential to help other people" avoid making the same mistakes.

Thirst excels supply

PEKING — As summer temperatures soared in this densely-populated Chinese capital, more and more workers were saying: 'Make it a Wuxung.' And that's been causing headaches for China's three state-run breweries — Wuxung, Peking, and Yanjin. They're striving to meet higher production quotas in response to growing consumer demand for beer. Chinese officials estimate public thirst for suds outstrips total beer production two-to-one. Availability is further restricted by corrupt officials, who siphon off 20% of the beer produced for resale on the black market, *The Globe and Mail* reports.

Scots target sniffers

LONDON — A dramatic increase in glue-sniffing has prompted Scottish authorities to introduce the Solvent Abuse Act, empowering a children's panel (Scotland's alternative to juvenile court) to order compulsory care for young solvent abusers. The Scottish Office reports that police files show an increase in glue-sniffing cases — to 3,300 in 1981 from 2,240 in 1979. Deaths caused by glue-sniffing rose to 14 in 1982 from only one in 1976. The legislation has not spawned imitators in England and Wales, where, says *The Sunday Times*, authorities consider "education and encouragement" preferable to court action.

Mistaken identity

IBIZIA — A brawl at a Spanish hotel has raised questions about drinks with look-alike labels. A vacationing British couple took exception to a Bacardi-size bill after an evening of imbibing drinks allegedly containing its cheaper imitator, Bacaly. In the ensuing melee, the British housewife scored with a punch to the eye of the house bartender. Undaunted by a subsequent trip to the local police station, the woman had the Bacaly analyzed by a Home Office expert upon her return home. Results confirmed Bacaly contained less alcohol than Bacardi. "It gave some people headaches and it didn't even smell like it should," she complained to *The Sunday Times*.

Boost drinking age

TORONTO — Alaska and Delaware are the latest of the United States to boost the drinking age to 21, bringing the number (including the District of Columbia) to 27. The legal age is 19 in 13 states, 20 in six others. Only four states permit the sale of alcohol to 18-year-olds.

Competing for limited resources

Health promo trend threatens EAPs

By Gary Lamphier

TORONTO — The trend toward health promotion programs represents a threat to the future of employee assistance programs (EAPs), says the national adviser to the federal government's EAP.

"Because so many groups are competing for the same dollar, a lot of EAP people are saying we've got to broaden our scope to encompass other functions, like stress management," said Wayne Corneil, national adviser, EAP, Medical Services Branch, Health and Welfare Canada. "But you can't be all things to all people. It diffuses the service EAPs are set up to give."

Corneil: stress

Mr Corneil made his remarks during the plenary session of Input '83, the Fifth Biennial Canadian Conference on EAPs and alcohol and addiction problems in the workplace, held here.

"Today we're in the business of competing for resources," he said.

Mr Corneil said the availability of funds to EAPs is also threatened by "charlatans" and "snake oil salesmen" who are passing themselves off to upper management as employee health experts.

"No matter what problem you have, (they say) it must be stress induced," said Mr Corneil, adding that management has become increasingly skeptical of health promotion proponents and their programs.

"This is not to suggest that there are not reputable, good programs out there. But as the real estate salesman said when I bought my house, 'May the buyer beware.'"

INPUT '83

More next month

Mr Corneil told **The Journal** that funds are being diverted to stress management and other health promotion programs when the money could be better spent on alcohol abuse problems in the workplace. He said professionals in the EAP field are shifting their focus away from alcohol, though many "wouldn't know an alcoholic if they fell over one."

Hardships compound risk to Native smokers

(from page 1)

As well, 17% of the Indian children, 11% of the Inuit children, and 2% of the non-Native children used snuff. Seventeen per cent of the overall population reported using chewing tobacco.

Margaret Thomson, a nurse with the Manitoba Lung Association who has worked in Northern Canada, said statistics indicating the high incidence of smoking among Native people across Canada, while scanty, "are really quite alarming."

She said in view of the poor living conditions, overcrowding, lack of sanitation, and other health problems which are common in many Native communities, the risks associated with smoking are only increased.

"We need more information about the smoking habits of Native people," she said. "As far as I can ascertain, there are no smoking programs for Native people," although she said some have been promised.

Mr Tologanak and Ms Thomson were addressing a session on smoking and minority groups at the Fifth World Conference on Smoking and Health held here recently.

Other delegates from the United States, New Zealand, and Australia also reported a high incidence of smoking among minority groups in their countries.

In the case of the Maori people of New Zealand, delegates were told 54% of the male and 58% of the female population were reported to be regular smokers. As well, the incidence of lung cancer among the Maori was 81 cases per 100,000 for men, and 45 per 100,000 among women. That compares to 47 (males) and 11 (females) per 100,000 in the general population.

"It seems to me," Mr Tologanak said, "that the cigarette has taken over the world. It's time some action was taken.

"I think we do have a problem and we owe it to our generations coming to put out that old cigarette."

In another presentation, Richard Stanwick, MD, assistant professor of pediatrics at the University of Manitoba's medical school, gave the results of a study he conducted on smoking patterns in students in Thunder Bay, Ont. He found that of 947 students who responded to the questionnaire in one high school, 38% of the boys had never tried smoking compared to only 25% of the girls.

"Girls are experimenting more than boys with cigarettes." Dr Stanwick added that he found girls were more likely to start smoking if their mothers smoked.

Dr Stanwick said boys are more likely not to smoke because of positive role models such as "a clean living fellow who sells jeans whose name is Wayne Gretzky."

Girls don't have a similar model, and "cigarettes are associated with the liberated woman," he said.

Young girls: they lack a positive role model

Community support 'disgraceful'

(from page 1)

And they have to be resolved in the face of "far less — absolutely, disgracefully less — support from the community at large than a broad range of other health areas." He referred among others to cancer, heart disease, stroke, arthritis, rheumatism, children's disorders, and maternal and child health.

"You name it. We have the least support from around the country of any health enterprise. And we have the most questions asked about whether we even are a health enterprise," Dr Mayer said.

However, he said, the issues that need to be addressed "from my point of view are much the same as they have been for some years now.

"They are issues to do with health insurance; issues of so-called responsible drinking, a term I don't like; issues of controlled drinking, of location of treatment and who should get it; issues having to do with advertising and free speech; issues that can be considered ethical, legal issues.

"Are we exploiting Medicare patients by readmitting and readmitting them at extremely high cost to give certain very specific kinds of treatment? What is appropriate treatment?

"Can we afford, as a society, to treat alcoholism, other than the very serious physical problems, in hospitals designed to treat physical diseases at 400 bucks a day?"

These are the questions and the issues "that are going to have to be resolved, and they can only be resolved by the people in the field, speaking with some clarity of vision and some purpose."

As for the Public Health Service, its primary mission is research, Dr Mayer said.

It and the institutes are "not in the business of generating policy positions for the government.

"We are very clearly charged," he said, with getting people together and with collecting information and scientific data upon which policy can be based.

Monson favors continent-wide info exchange

(from page 1)

Mr Monson said in addition to national and state leadership, three other issues are of immediate concern — prevention, funding, and controls.

To facilitate broad exchange of views, he would like to revive the idea of large North American meetings every year or two that draw together people not only from across the US but also from Canada and, possibly, Mexico.

Mr Monson was one of about 40 leaders in the field across the US who attended the 1st National Invitational Policy Forum on Alcohol and Other Drug Problems held here in late July.

Participants represented private, public, treatment, and prevention sectors, and local, state, and national bodies. Discussion centred on policy issues.

Influx of cheap, pure heroin puts new pressures on US

By Harvey McConnell

WASHINGTON — A rise in heroin-related hospital admissions and overdose deaths across the United States is being attributed to cheaper and purer supplies on the streets and increased use of heroin by middle-class cocaine abusers.

Figures compiled by the US Drug Abuse Warning Network (DAWN) of the National Institute on Drug Abuse show heroin overdose deaths rose from 474 in 1980, to 601 in 1981, and 771 in 1982.

Hospital emergency-room admissions related to heroin reported by the DAWN rose from 7,784 in 1980, to 9,271 in 1981, and 11,538 in 1982.

Average price for 1 mg of heroin has dropped to $2.22 today from $2.34 in 1980, and average purity has risen to 5.6% from 4% over the same period, says the US Drug Enforcement Administration (DEA).

Although the majority of heroin users live in poor, inner-city areas, a rising number of middle-class men and women are becoming hooked on the drug because they use it to moderate the crash from a cocaine high.

More than 50% of the heroin entering the US comes from the Southwest Asian countries of Iran, Afghanistan, and Pakistan, and is dominant in the eastern part of the US. Some 36% is smuggled from Mexico and is dominant in the midwest and west, and 10% comes from the Golden Triangle countries of Thailand, Burma, and Laos and is dominant in the west.

The immediate future does not augur well, according to DEA estimates.

Southwest Asian producers have ample supplies of opium stockpiled. There is little chance of suppression in Iran because of its political instability and in Afghanistan because of the Soviet invasion.

The Pakistan government has difficulty at the best of times in trying to control the fierce Pathan tribesmen in the Northwest Frontier Province who cultivate the opium poppy. At present the government does not want to antagonize them unduly because of the Soviet presence in neighboring Afghanistan.

Mexico's current economic problems may tempt more people to risk growing the opium poppy and smuggling heroin into the US despite government eradication programs.

In the Golden Triangle there have been record harvests. Supplies are plentiful even with several major suppression operations by the Thai government against the Shan United Army which controls drug trafficking on the Thailand-Burma border.

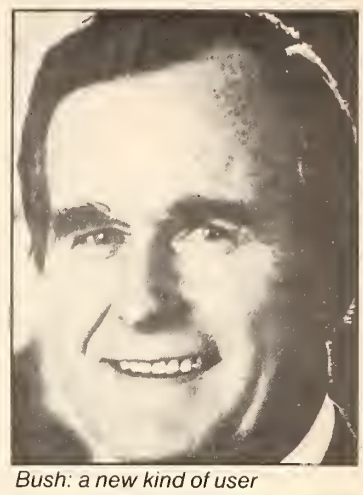
The rise in heroin availability is a major target of the National Narcotics Border Interdiction System created by US President Ronald Reagan. The inter-agency cooperative effort is directed by Vice-President George Bush, who headed the widely-publicized South Florida task force against drug smuggling from South America. (**The Journal**, Oct, July, April, 1982).

Regional offices of the new national network have been set up in New York, Chicago, New Orleans, El Paso, Miami, and Long Beach, Cal. The network will ferret out information about US-bound shipments from Central Intelligence Agency agents abroad, and from the US military, Coast Guard, Customs Service, the DEA, and the Federal Bureau of Investigation.

In one of its first operations, the network has arrested a US Army chief warrant officer only a month away from retirement, his Thai-born wife, and four other Thai nationals for smuggling 90% pure heroin into the Washington and Los Angeles areas.

Meanwhile, the influx of cheaper and purer heroin is being seen in Washington, DC. The US capital is suffering from the worst outbreak of heroin use since the early 1970s. There were 133 heroin overdose deaths in the city in 1982, and 865 heroin-related, hospital emergency room admissions.

However, a study for the city government by the US Centers for Disease Control has found that many of the overdose deaths are not of hard-core addicts but of people in their early 30s lured by lower prices and higher purity into "chipping," or using heroin for recreation on sporadic occasions.



Bush: a new kind of user

In the past two years there has been a tremendous increase in police activity, ranging from the "jump out" squads which nab dealers on the streets, (**The Journal**, March) to undercover agents posing as sellers. The result is that in 1982 police arrested 6,500 people on drug charges, or 26% of all arrests made in Washington.

City judges and prosecutors are complaining about the number of drug-related cases scheduled to be tried, and officials estimate that about 75% of the inmates in the city jails are drug abusers.

Ironically, the crime rate in Washington dropped by 11% in 1982. Police officials said this is partly due to a decrease in the price of heroin, which means addicts have to steal less to pay for their supply.

Treatment resource audit shows high utilization

WASHINGTON — A biennial survey of drug and alcohol treatment resources has found that on Sept 30, 1982, the United States had the capacity to treat 345,215 alcohol abusers and 196,289 drug abusers.

The figures were tabulated from more than 90% of known treatment units in the US which reported to the survey conducted by the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse.

Utilization of these resources on that day ran at 84.3% of capacity for alcohol abuse and 88.3% for drug abuse, among 2,729 alcohol abuse treatment units, 1,514 drug abuse units, and 1,504 polydrug abuse units.

What effects federal budget cuts and the advent of block grants have had will not be known until another survey is done in 1984.

Impressively similar to stateside counterparts

Children of military carry drug habits abroad

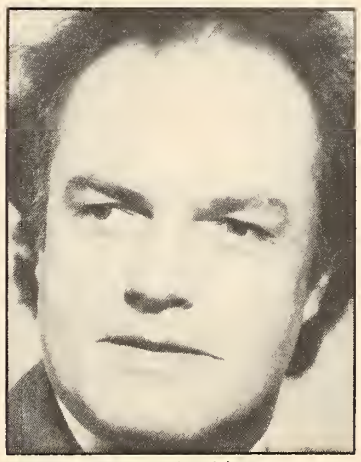
By Harvey McConnell

WASHINGTON — High school students attending United States military schools abroad carry their stateside drug habits with them, a joint study for the US National Institute on Drug Abuse (NIDA) and Department of Defense (DOD) reveals.

A study of 2,400 seniors in 33 DOD schools abroad was carried out by Lloyd Johnston, PhD, and colleagues from the University of Michigan. It is similar to the annual survey of 18,000 US seniors in 142 schools Dr Johnston does for the NIDA (**The Journal**, April).

Although there are variations among the two groups, Dr Johnston concludes that the patterns of the overseas students "are impressively similar to those of their stateside counterparts."

The similarities "bear testimony to the degree to which the dependents of American military overseas carry the cultural habits of their society with them, since these drug usage rates very likely contrast sharply to those in surrounding communities overseas."



Johnston: cultural habits

Highest rate of illicit drug use was reported by 59% of the high school seniors in North Germany, followed by 56% in the Mediterranean region, 53% in South Germany, 45% in the Pacific and Atlantic regions, and 38% in the Panama region.

Dr Johnston finds that fewer of the seniors abroad use cocaine, amphetamines, nitrite inhalants, and methaqualone than their counterparts in the US, but more use other inhalants, tranquillizers, barbiturates, heroin, and other opiates.

Availability is a major factor: tranquillizers, heroin, and other opiates are more readily obtained abroad.

Overall, the study finds that 64% of both US and overseas students have tried an illicit drug, and approximately 40% have tried an illicit drug other than marijuana. However, daily marijuana smoking is lower among the overseas students (4%) than among those in the US (6.3%).

There are differences in alcohol and tobacco use: daily drinking is reported by 8.5% of the overseas students compared with 5.7% in the US, and daily cigarette smoking is reported by 26% of the overseas students compared with 21% in the US.

Overseas students exhibit somewhat less disapproval of all types of drug use, although they agree with their stateside counterparts about the risks for users of various drugs, with the exception of marijuana and alcohol.

Dr Johnston said a possible explanation is that fewer of the overseas students drive cars, where alcohol and marijuana use could put them at risk, and that students in the US have become more aware of the risks in the past several years.

Both the overseas and US students support laws prohibiting drug use, although more overseas students were tolerant of smoking marijuana in private and getting drunk in private.

Dr Johnston found that in both groups there is less drug use of any kind among students who plan to attend college.

Like far out — a checklist for the new revival

By Wayne Howell

According to Alan Furst, writing in the August issue of *Esquire* magazine, we are in for a 60s revival. Furst's antennae were set a-quivering by the recent publication of three books about LSD: a re-issue of *The Psychedelics Encyclopedia*, the appearance of the memoirs of Albert Hofmann, the Swiss chemist who discovered LSD, and the publication of the memoirs of Timothy Leary.

Furst admits he might be a little premature and/or paranoid in predicting a 60s revival, but the idea is really not as preposterous as it might appear. After all, the late 1970s saw a 50s revival in the form of movies such as 'Grease' and music such as 'new-wave' which was nothing more than Bill Haley and the Comets revisited. If the 50s are already grist for the nostalgia mill, can the 60s be far behind?

If a 60s nostalgia-trip is coming we had better get prepared for it. I have compiled a little check-list of things to do in anticipation of a 60s revival. I offer it here as a public service:

1) Practise dressing in an eccentric manner so as to better express your individuality. The best way to do this is to check out what other people around you are wearing and then conform to whatever pattern of eccentricity is prevalent. That's the way it was done in the 60s. But in the 60s it was sometimes difficult to find the proper eccentric gear. That will be no problem in the 80s: if we are going to have a 60s revival there will undoubtedly be Calvin Klein bell-bottoms and Yves St Laurent tie-dye shirts available in the better stores, and knock-down versions of same that you can pick up for a reasonable price at K-mart and Woolco.

2) Buy a T-shirt with a marijuana leaf on it.

3) Re-read all the works of Herbert Marcuse, Carlos Castenada, Aldous Huxley, and Marshall McLuhan. If this sounds like a pretty tall order, forget it. Very few people who talked about those writers in the 60s actually read what they wrote. If you could fake-it in the real 60s you should be able to fake-it just as easily in the 60s revival.

4) Practise talking a lot about drugs. You don't actually have to take them. Just talk about them all the time.

5) Practise expanding your vocabularly in an unintelligible direction. In the 60s clean-shaven explorers of outer space looked back on our planet. Some described it as 'bee-yutiful'. Others saw it as 'byew-tiful'. Others were quite convinced it was 'beautiful.' The astronauts, strange fugitives from the 40s, were intelligible, but not articulate. The hirsute 60s explorers of inner space, on the other hand, were articulate, but not intelligible. They had out-of-mind trips that were 'out of sight.' While their cortical neurons tripped the light fantastic, they had 'heavy' experiences.

If you want to get into the swing of the 60s revival, practise using vague amorphous words, separated with significant pauses fraught with transcendental meaning. (Example: you could rephrase the last sentence like this — 'If the 60s thing is your bag . . . flash on coming off the wall a lot . . . I mean like wordwise . . . dig.') And say 'man' a lot, even if you are talking to a woman. Don't be afraid of leaning on her space; she'll know where your're coming from.

NEWS

A 'distinctive hand pattern profile'

X-ray may provide extra FAS detection aid

QUEBEC CITY — Hand x-rays can prove a valuable tool in detecting children with suspected fetal alcohol syndrome (FAS), says a Saskatchewan radiologist.

Stuart Houston, MD, of the University of Saskatchewan, Saskatoon, told the annual meeting of the Canadian Association of Radiologists here that FAS children have a distinctive hand pattern profile.

Dr Houston credited British Columbia radiologists Betty Wood, MD, and Don Newman, MD, as the first to notice that children with FAS had shorter terminal phalanges (finger-tip bones), especially in the little and index fingers.

But it was Dr Houston who actually collected and measured data on the subject and compared the hands of FAS children with normal children.

He said the distinctive facial features (including short palpebral fissures, small eyes, short nose, epicanthus, and a very thin and flat upper lip) are usually sufficient to make an accurate diagnosis of FAS. But, he said, the discovery of the distinctive hand pattern "could be very helpful" in confirming a diagnosis, especially when the mother denies drinking during pregnancy or when the history of the child is not known.

Dr Houston said it is possible to use the hand pattern for diagnosis after the child is one year of age.

His study involved the examination of 86 hand and wrist x-rays taken of 77 children who were part of a group of 137 children of mothers with a history of maternal drinking. They were being studied by Witold Zaleski, MD, head of the Alvin Buckwold Centre for mental retardation at University Hospital, Saskatoon.

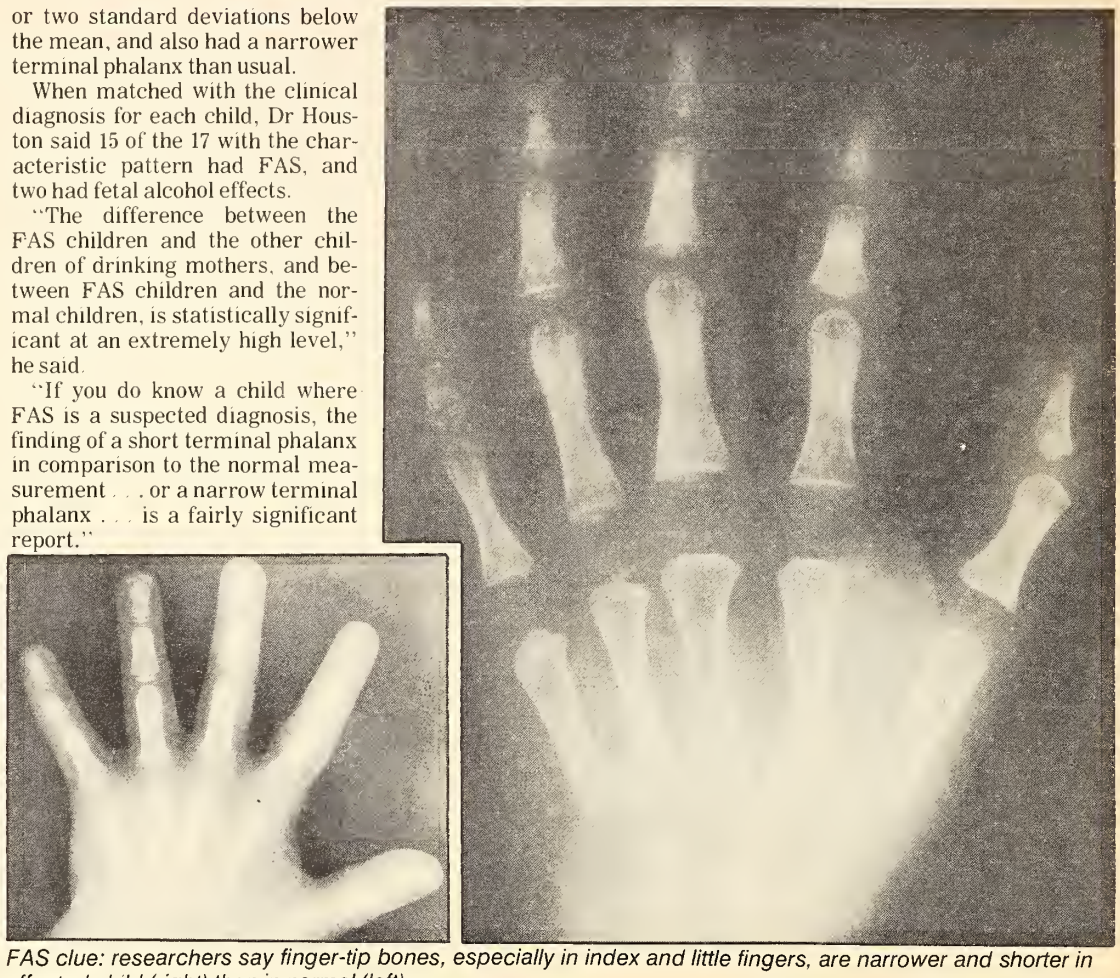
Dr Houston measured the lengths of all hand bones and the widths of the terminal phalanges in the x-rays and then determined an individual hand pattern profile for each of these subjects without knowing the clinical diagnosis of the child.

In evaluating the x-rays, he said, he discovered a characteristic pattern in 17 of the children (between two and six years of age) who had a similar length profile pattern one or two standard deviations below the mean, and also had a narrower terminal phalanx than usual.

When matched with the clinical diagnosis for each child, Dr Houston said 15 of the 17 with the characteristic pattern had FAS, and two had fetal alcohol effects.

"The difference between the FAS children and the other children of drinking mothers, and between FAS children and the normal children, is statistically significant at an extremely high level," he said.

"If you do know a child where FAS is a suspected diagnosis, the finding of a short terminal phalanx in comparison to the normal measurement . . . or a narrow terminal phalanx . . . is a fairly significant report."



FAS clue: researchers say finger-tip bones, especially in index and little fingers, are narrower and shorter in affected child (right) than in normal (left)

RESEARCH UPDATE

Smoking and uterine cancer

A study aimed specifically at examining the connection between cigarette smoking and cervical cancer shows a strong, direct association independent of other risk factors. The case-control study matched black women 17 to 55 years of age attending the Dysplasia Clinic at Grady Memorial Hospital in Atlanta with women attending the Family Planning Clinic at the same hospital. Controlling for age, number of sexual partners, age at first intercourse, socioeconomic status, and oral contraceptive use, researchers from the Centers for Disease Control found that cigarette smokers were at an increased risk of dysplasia and cancer of the uterine cervix. This risk increased with cumulative exposure to smoking as measured by pack-years smoked, and was more strongly associated with cancer and severe abnormalities than with milder dysplasia. The study said a causal association between smoking and cervical neoplasia (new abnormal cell growth) "is biologically plausible . . . A reduction in the risk of cervical cancer appears to be another inducement for young women not to start smoking, or if they do smoke, to quit," the researchers concluded.

Journal of the American Medical Association, July 22/29, 1983, v.250:499-502

On-base hazardous drinking

Two different methods of estimating the prevalence of problem drinking in the Canadian Armed Forces have placed 18% of this population in the hazardous drinking category. A study in 1976, at a primarily air-oriented operational base in central Canada, estimated the level of 'on-base' alcohol consumption and then calculated the amount of on-base drinking by analyzing alcohol sales in the messes. The other study, also conducted by the Addiction Research Foundation of Ontario, used questionnaires to measure the prevalence of alcohol consumption at a primarily land-oriented training base in central Canada. While the first study placed 18% of the military personnel at or above a level of consumption hazardous to health, the second study closely paralleled this finding by concluding 17.7% of military personnel were classified as presumptive or actual problem drinkers. The researchers said the closeness of these two estimates "gives rise to considerable concern." They concluded that education and assistance programs aimed at high-risk groups, such as young, single males of junior rank living on base, should be continued and strengthened, and the number of alcohol outlets on base should be revised.

Journal of Occupational Medicine, July 1983.

Diazepam withdrawal

Long-term users of diazepam in gradual withdrawal can still experience withdrawal symptoms. This is one of the findings in a study by Peter Tyrer and Robert Owen of Mapperley Hospital, Nottingham, and Sheila Dawling of Guy's Hospital, London. In the double-blind study, the researchers withdrew 41 outpatients from the drug over three months by stepwise reduction, with half reducing their dosage immediately and half after eight weeks. Overall, 44.4% of the patients experienced withdrawal symptoms, which the researchers described as "disturbing," because they had hoped a slow withdrawal of diazepam would perhaps prevent any abstinence syndrome. Personality appeared to be by far the most important predisposing factor for withdrawal reactions. "Although gradual withdrawal is less likely to result in severe withdrawal phenomena than sudden cessation of treatment, some patients still suffer significant distress," the study said. In some people susceptible to withdrawal symptoms and other psychiatric disorders on the halting of benzodiazepines, the researchers concluded that permanent drug maintenance therapy may be "the least of several evils."

The Lancet, June 25, 1983, No.8339:1402-1406 **Pat Rich**

US spraying programs continue

Paraquat safety questioned again

WASHINGTON — Scientists at the United States Centers for Disease Control (CDC) and the US National Institute of Environmental Health Sciences (NIEHS) are disputing reports by the US Department of State that paraquat-sprayed marijuana does not endanger the health of smokers.

The report by CDC and NIEHS scientists in the *American Journal of Public Health* (July), appears as the US government moves ahead with efforts to have paraquat-spraying programs initiated in countries abroad, chiefly Colombia.

Philip Landrigan, MD, and colleagues claim that the herbicide could produce chronic pulmonary fibrosis (lung tissue scaring) among heavy smokers.

They say that between 150 and 300 marijuana smokers in the US were projected to have been exposed to unhealthy levels of the herbicide each year from 1975 to 1979 following US-assisted spraying in Mexico.

Studies by the US Department of State have shown there is no appreciable health risk, and as yet no proven case of paraquat-induced lung damage, from smoking marijuana sprayed with paraquat.

The Landrigan *et al* study followed the discovery in March, 1978, that 13 of 61 marijuana samples from the southwestern US were contaminated with paraquat. Following a nation-wide survey of 910 batches of marijuana the researchers also found that 33 of these seized batches were found to contain detectable paraquat. Of the 180 specimens obtained in states adjacent to Mexico, 23 were contaminated with paraquat. No contamination was found among samples from the eastern seaboard or the Pacific northwest.

Using the estimate that 0.2% of sprayed paraquat passes unchanged in marijuana smoke, researchers said that during one year about 0.1% of US marijuana smokers would inhale about 100 micrograms or more of paraquat. Judging an annual dose of 500 micrograms of inhaled paraquat as being capable of producing pulmonary damage, the study said up to 300 US marijuana smokers might be at risk.

Although no acute or chronic cases of paraquat poisoning were detected, Dr Landrigan said no systematic search for such cases was undertaken.

The study said the risk of exposure was greatest among those smokers who made one large purchase of marijuana per year.

Under a bilateral agreement, paraquat was sprayed on marijuana and opium poppy crops in Mexico between 1975 and 1979, when the US Congress suspended financial support. The ban was repealed by Congress at the end of 1981.

Commenting on the report, Pat McKelvey, spokesman for the White House Office on Drug Abuse Policy here, said the report by Landrigan et al was based on old statistics, and there is nothing new on the subject. "Why it is turning up now is a matter of speculation."

He added that when the CDC and NIEHS had an opportunity to review "everything we are doing, nothing like this came up, and they signed off on it like everyone else."

The report is not expected to influence efforts by the government either to push for use of paraquat on marijuana crops in the US or to initiate a spraying program abroad.

NIAAA's director brings family medicine focus

WASHINGTON — Psychiatrist Robert G. Niven, MD, has been appointed — after months of speculation — director of the United States National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Canadian-born and educated, Dr Niven is the former director of the adolescent alcohol and drug abuse service at the Mayo Clinic in Rochester, Minn. He succeeds John DeLuca, who stepped down two years ago as NIAAA director (The Journal, Nov, 1981).

William Mayer, MD, administrator of the Alcohol, Drug Abuse and Mental Health Administration of the US Public Health Service has been acting director since Mr DeLuca's departure. (See page 1.)

Margaret Heckler, secretary of health and human services, which oversees the US Public Health Service, in announcing Dr Niven's appointment, said "his first-hand knowledge of adolescent drinking problems and the dynamics of family interaction in treatment and prevention adds a thrust and an important dimension to our drive against teenage alcohol abuse."

Niven: teens

Dr Niven is a board-certified psychiatrist with previous medical experience as a family physician. He is a member of both the American Psychiatric Association and the American Medical Association, and is president of the Association for Medical Education and Research in Substance Abuse.

COMMENT

GILBERT

'. . . if high driver fatality rates . . . are to be the only reason for raising the legal drinking age, then serious consideration should be given to raising the age to 25 years for men and reducing it to 18 years for women.'

The drinking age debate

By Richard Gilbert

I know in advance that what I am going to propose this month is unpopular. I will argue that the age at which people can purchase alcohol and drink alcoholic beverages in public (the legal drinking age) should be same as the age of majority. Thus I will propose that in Ontario, where the age of majority is 18 but where the legal drinking age is 19, the drinking age should be *lowered* by one year, or, alternatively, that the age of majority should be raised. A Gallup poll conducted in June indicated that 62% of Canadians favor a national law that would raise the drinking age to 21. The support in Ontario was 69%.

Let me say at the start that I am deeply concerned about the amount of drinking and driving that goes on in Ontario, and especially distressed by the number of young people whose lives have been curtailed or ruined because they were foolish enough to drink and then drive. I'll be making some proposals to reduce these tragedies later in this column.

Follows logically

Let me say too that I have little doubt that raising the drinking age to 21 would reduce the number of serious accidents and fatalities. Indeed, presuming that the change would be effective in reducing the amount of drinking and then driving by 19- and 20-year-olds, and acknowledging a wealth of data that drinking makes it more likely that a driver will have an accident, it follows almost logically that there would be fewer road accidents and fatalities if the drinking age were raised.

In a recent review, Evelyn Vingilis and Katherine De Genova of Ontario's Addiction Research Foundation (ARF) concluded that "studies on raising the legal drinking age suggest that the laws may have had some effect in reducing consumption, alcohol-related problems, and collisions, although methodological considerations preclude measurement of the extent of the impact." The study most often cited by advocates of a higher legal drinking age was reported in 1981 for the US Institute for Highway Safety. In nine states where the drinking age was raised there were 28% fewer night-time fatal accidents among the affected age group than in nine neighboring states where the age remained unchanged.

So that readers of **The Journal** can get a feel for what is happening in Ontario, I have set out in the table below the most recently available data on driver fatalities. Note that the data represent *all* driver fatalities, whether or not alcohol was presumed to have been a factor. Researchers believe that for a population the size of Ontario total driver fatalities provides the best measure of the impact of a possible change in the law concerning alcohol use.

The table shows the rate at which young drivers died in motor vehicle accidents in Ontario between 1975 and 1981 (including motorcycle and moped drivers), compared with the average rate for all drivers. Two significant changes in legislation occurred during this period. Seatbelt use became mandatory on Jan 1, 1976. The legal drinking age was raised from 18 to 19 years on Jan 1, 1979 (with an exemption for people who were 18 years old on that date). The substantial decline in total fatalities from 1975 to 1976 can almost certainly be attributed to the increased use of seatbelts. There was no such overall decline after the drinking age was raised.

Any effect of raising the drinking age from 18 to 19 years in 1979 would seem from the table to have been delayed. It was not until 1981 that a clear decline ocurred in fatalities among 16- to 18-year-olds. Regrettably, 1982 data are not yet available to determine whether the low 1981 rates were sustained or whether they were statistical freaks of the kind that produced an unusually low rate for 19-year-olds in 1976. So far we know only that overall driver fatalities in Ontario were sharply down in 1982: a total of 592 compared with the 1981 total of 751.

Delayed effect

The delayed decline in relative fatality rates among 16- to 18-year-olds is consistent with data from the biennial survey of Grade 11 and 13 Ontario students conducted for the ARF. In 1981, compared with 1979, the students reported drinking less, driving less after drinking, and being involved in fewer automobile accidents.

A good question to ask is the extent to which all these changes can be attributed to the change in legal drinking age in 1979. My own guess is that a more potent factor has been the decline in the economy. People both drink less and drive less when times are hard, and young people have been especially affected by the recent recession. Thus we should expect to find that the low fatality rates among 16- to 18-year-olds were sustained, but that increases will occur this year as the recession moderates.

I should stress that by invoking economic factors I am not denying the possible impact of raising the legal drinking age. Rather, I am attempting to put it in a context. Another part of the context is the relatively high rate of driver fatalities among 21- to 25-year-olds, averaging some 50% above the average for all drivers, as shown in the table. Yet another part, not shown in the table, is the enormous difference in accident rates among male and female drivers. In 1981, for example, an 18-year-old woman was less likely to be involved in a motor vehicle accident than a man aged between 35 and 44, whereas an 18-year-old man was almost three times as likely to have an accident as the older man.

It follows that if high driver fatality rates (or some other indication of impaired driving) are to be the only reason for raising the legal drinking age then serious consideration should be given to raising the age to 25 years for men and reducing it to 18 years for women. The main point I want to make in this column is that a matter such as this should not be decided on the basis of one kind of statistic or one kind of concern. There are very many other considerations in changing the age at which things are permitted in our society. Most important is the concept of the age of majority.

Twenty-five years ago in Britain I was 18 years old and legally able to buy alcohol and consume it in public, but I was not able to vote, stand for public office, sign a contract, or marry without my parents' consent. I was not responsible for my debts. At that time, the age of majority in Britain was 21 years. One approached the assumption of these important responsibilities with some apprehension.

Today, in Ontario, the age of majority is 18 years, but adults have to be 19 years to buy alcohol or drink it in public. In my view, it is a complete distortion of priorities to hold that a person is old enough to vote, hold public office, and sign contracts, but not to buy alcohol or consume it in public.

It is not simply the distortion of priorities that disturbs me. I am concerned about the dilution of the concept of the legal age of majority that is inherent in setting an age of permission higher than the age of majority. The notion of a clear age of adulthood is an extremely useful cultural device. It enables appropriate preparation and anticipation, and the realization of a sense of full responsibility for one's own behavior once the age of majority is attained.

I was the guest for a recent radio phone-in show on this topic. A 19-year-old called in to disagree with me, saying that having too much responsibility at once was confusing. I agreed that this might be the case for him and suggested two solutions. One was that the age of majority could be raised, to allow more time for young people to be prepared for their adult responsibilites. The other was that there could be better preparation even if the age were not raised.

Perhaps in 1971 the Ontario government erred in lowering the age of majority to 18. I am inclined to believe that 18 is an appropriate age, but I would argue strongly for better training for adult responsibilities, including those connected with the use of alcohol.

Equal time

A discussion about the ages of legal permission should also consider other behavior that society regulates through legislation. One such behavior is driving an automobile. Remembering that alcohol-related traffic accidents have symmetrical causes — drinking *and* driving — equal time might be given to arguments for raising the age at which operating an automobile is permitted.

I should not overlook the only two other things, apart from buying and drinking alcohol in public, that, to my knowledge, are limited by law in Ontario to people older than 18 years. The first is driving a school bus. The second is being a federal civil servant. Only people aged 21 and older may do these things. In my view, there is as little justification for these requirements as there is for the age limits on the purchase and consumption of alcohol. It is especially absurd that an 18-year-old could be the prime minister of Canada and yet could not be a filing clerk in the prime minister's office.

Another point that should be made is that if the drinking age were raised to 21 years in Ontario, as has been proposed by Toronto City Council (by an 11 to 9 vote) and other bodies, the likely reduction in motor vehicle accident fatalities (including drivers, passengers, and others) would be no more than about 3% of the total at best. To save 30 or so lives out of a total of more than 1,000 should not be sniffed at — every death is a tragedy — but the possibly much greater impact of other measures should be acknowledged. The remarkable effect of the seatbelt legislation has already been noted, and yet still there were 31,203 drivers involved in accidents in Ontario in 1981 who were known to have not been wearing their seatbelts.

Proposals

I would like to see more attention paid to reducing the extent to which drinking and driving is regarded in our society as acceptable behavior. Most people I know drink and then drive and think nothing of it. Mostly they do it with impunity. The chances of being caught while driving with a blood-alcohol level of more than 0.05 milligrams/100 millilitres are slight — less than one in 1,000 — and the chances of having an accident are even slighter, even though the probability that an accident will occur is assuredly enhanced by the presence of the alcohol. The surest route to reducing the acceptability of drinking and driving is probably not increased enforcement — though that would help — but development of a sense of concern that our patrons and guests are leaving us in a dangerous condition.

The law could be used to instill such a sense of concern. I proposed in my Feb, 1982 column that the law be changed so as to make licensees and hosts culpable when a person they have given alcohol to is found to be driving with too much alcohol in his or her blood. As a result, a restaurant owner, for example, would ensure that waiters and waitresses asked about a customer's driving intentions when a second bottle of wine was ordered. A party host would strongly encourage guests not to bring their cars and would strive to keep those that did away from the bar.

I would like to repeat this proposal. In Ontario at present we have a limited form of this kind of law. A licensee can be liable for damages caused by a person served alcohol under his or her auspices, when that person subsequently drives, but damage has to be caused for there to be liability. (In a recent case, in which a car passenger was awarded $1.15 million by the Ontario Supreme Court after he had been paralyzed as a result of an accident, the Court ruled that a hotel owner was partially responsible because the hotel had served beer to the victim and the driver, both of whom were under age at the time. The hotel owner is appealing the ruling. He says that he did not serve beer to the two boys.)

My proposal would go much further. Damage would not have to be done by a drinking driver for the licensee to be culpable. Legal liability would be incurred simply if the recent customer were driving while impaired. Also, non-commercial serving of alcohol would be included, so that we would all have some responsibility for our guests.

Proponents of raising the drinking age point out quite rightly that a young adult is both a new drinker and a new driver and it is the combination of the two that may be especially lethal (combined, of course, with youth's impetuousness). Dr Vingilis has suggested to me (among many other things) that perhaps we should make more use of the probationary period of two years or more that follows the initial granting of a driver's licence in Ontario. Her suggestion is that vehicles driven by drivers on probation should be required to carry a distinguishing sign, both as a warning to other drivers and as signal to police officers to be especially watchful for possible infractions of the drinking and driving laws. I certainly concur with this suggestion. It would, in my view, be a much more effective approach to the problem of inexperience than raising the legal drinking age.

FATAL ACCIDENTS TO ONTARIO DRIVERS — 1975-1981

	1975	1976	1977	1978	1979	1980	1981
Relative fatality rates* for the following ages:							
16	3.1	3.6	4.2	3.6	2.8	2.9	1.3
17	2.4	2.2	2.3	2.6	2.3	2.0	1.5
18	2.4	2.3	2.1	2.4	2.5	2.6	1.6
19	2.9	1.9	2.5	2.5	2.4	2.4	2.5
20	2.0	2.6	2.3	2.3	1.8	2.1	2.8
21-24	1.3	1.4	1.5	1.7	1.7	1.5	1.5
25-34	0.8	0.9	0.8	0.9	0.9	0.9	1.0
Actual values — all drivers:							
Driver fatalities	880	731	697	703	746	763	751
Fatalities 100,000 drivers	21.6	17.4	15.7	15.3	15.8	15.7	15.1

*For example, the fatal accident rate among 16 year olds in Ontario in 1975 was 3.1 times the average rate. The actual driver fatality rate per 100,000 16-year-old drivers in that year was 67.4.

Source: Ontario Motor Vehicle Accident Facts, 1975-1981, Ministry of Transportation and Communications.

NEWS

Family intervention should be tough and loving . . .

By Harvey McConell

PHILADELPHIA — A family's intervention with an alcoholic member has to be properly thought out and prepared, or it may be doomed to failure, believes Mona Monsell, president of the Freedom Institute in New York City.

At the same time, intervention is often misunderstood and seen as "a really mean thing: we are all going to pounce on the alcoholic," she told the National Conference on Alcoholism and the Family here.

Ms Monsell said she likes the term "tough love" because an intervention "has to be tough and it has to be loving."

Before a family intervention is decided upon, counsellors must make sure there is an alcohol problem in the family; sometimes early probing has uncovered a marital and not a chemical dependency problem.

Ms Monsell said too often approaches are made for help in the late, instead of early, stages of alcoholism. She gets "awfully tired" of hearing the defence that the alcoholic partner "is not that bad yet."

Many wives are reluctant to include their children in family conferences before an intervention. "But you can't protect children, and it is amazing that so many families come in and, for the first time ever, sit down together and talk about the drinking problem," she said.

Ms Monsell said the aim should be to gather the relevant information on the situation so the family can present it to the alcoholic in a non-judgemental way.

"Unless there is cohesiveness, then there is no effective intervention."

A counsellor should be present during the intervention, which should not be done in the home as that gives the alcoholic a certain amount of power.

She and her colleagues at the institute prefer to refer alcoholics to different treatment centres "so that the alcoholic will not feel we are intervening just to fill a bed." But a bed must be available somewhere on the day of intervention "because with an alcoholic, if they don't go that day they have a million excuses the next day on why they can't go."

Ms Monsell said that in her experience intervention is successful about 80% of the time in getting an alcoholic into treatment. "Intervention is always good in that families themselves are helped by at least being able to present their data and tell the alcoholic in a structured setting how they feel."

If intervention fails, family members must be helped to stick together and to present a united front to the alcoholic, who will often try to divide and conquer.

Many treatment centres report that intervention, even if it fails initially, can work eventually as many of the delusions and denials of the alcoholic gradually break down.

. . . but it also needs careful rehearsal

By Betty Lou Lee

HAMILTON — Family intervention was a recurrent theme at the 24th annual Institute on Addiction Studies, held here at McMaster University by Alcohol and Drug Concerns, Inc of Toronto.

No one advocated it more passionately than Bob Moore, a 62-year-old Seneca Indian who claims six marriages, six coronary bypass operations, and 24 years of sobriety.

He is former director of the American Indian Commission on Alcohol and Drug Abuse, a director of the National Council on Alcoholism in the United States, and has been involved in educational programs in addictions at the universities of California at Santa Cruz, and of Utah.

He said the time to do something about a person with a chemical dependence is when it is first seen.

"We used to say you have to precipitate a crisis. But if my brother is having problems, and I know it, do I love him so much I kill him with my cruel kindness and ignore it?

"You get all the significant people together, and you flat love him to death so he has no place else to go but for help . . . You don't criticize the person, but the behavior."

Before any counselling or therapy can be effective, the "two-inch, stainless steel, transparent veil of denial people put around them about their addiction must be pierced," Mr Moore said.

"The word 'confrontation' brings up a negative event. But it can be a loving and gentle event, proving those intervening love the patient enough to confront him or her about the addiction in specific terms: 'When you were drinking on July 18 . . .'."

These sessions should be rehearsed, possibly weekly for six weeks, selecting the best people to take part in the confrontation, and the best example of behavior each one has.

He told of one Native community of 500 with an alcoholism rate of 97% that has been chemical free for seven years since the chief and council took intervention training, and forced 67 members to take treatment. One of them was the bootlegger, the chief's mother.

A similar message came from Linda Bell, director of operations for Bellwood Health Services Inc, of Toronto. It promotes programs developed at the Donwood Institute, a treatment centre founded by Dr Gordon Bell, MD, her father.

"Anger, resentment, and judgement will put anyone's back up," Ms Bell noted. "They know how to deal with anger, they manipulate it all the time."

Excuses should be predicted and the group should know how to deal with them.

Side-effects of injecting need study

Surgery for addicts is 'frustrating'

By Lilllian Wylie

MONTREAL — Too little study has been devoted to one side-effect of the increase in 'skin-popping' drug abusers — the demand for plastic and reconstructive surgery, or even amputation, to remedy injuries sustained by abusers, says a United States surgeon.

Richard Marfuggi, MD, of New York University Medical Center and the Institute of Reconstructive Plastic Surgery, New York, claims the lack of literature on the subject leaves surgeons to rely on their own wits: "There exists no classification of this disease process and treatment is often empiric," he told an audience here at the 8th International Congress of Plastic Surgery.

Dr Marfuggi and his associate, David Chiu, MD, studied 124 addicts, aged 20 to 50 years and including 38 women, admitted to New York's Bellevue Hospital. All had injuries to the arms and hands stemming from chronic drug abuse by injection; complications ranged from abscesses through ulcers, gangrene, and septic arthritis, to osteomyelitis.

"Drugs abused were multiple and usually included heroin and cocaine," Dr Marfuggi reported. "Clinical stages reflected the natural progression of the disease from single to deep tissue planes, and from single to multiple tissue systems."

The first of the four stages of disease progression was characterized by inflammation, and was amenable to parenteral antibiotics (cephalosporin). Incision and drainage was required where abscesses existed, Dr Marfuggi said. Most of the 129 admissions fell into this category, and hospitalization was confined to no more than five days.

For this group, "antibiotics were always administered by the intramuscular, rather than the intravenous route, as the latter provided an easy access for self-injection during hospitalization," Dr Marfuggi said. Frequently, patients signed out against medical advice, because of failure to obtain desired quantities of pain medication.

Stage two patients were more seriously ill, sometimes requiring secondary skin grafting. "These patients were usually the overdose victims who, in addition to the local insult of injection, added prolonged positional pressure and vascular compromise to the extremity while unconscious," he noted.

This group included patients who had injected into tendon sheaths while searching for vascular access. Hospitalization was needed until wounds closed — usually 10 to 14 days.

Stage three patients were fewer in number, and included those with chronic drainage ulcers, stiff or open joints, and ruptured or scarred tendons. "Reconstruction required skin grafting for the ulcers, arthrodesis, arthroplasty, or deletion for the finger joint injuries," said Dr Marfuggi.

The most serious stage — stage four — had been reached by seven of the 129 patients, several of whom had lost any use of the arms and hands. Two suffered from septic arthritis; two had osteomyelitis of the proximal phalanx, necessitating amputation; and three patients sustained osteomyelitis of the radius (the bone on the thumb side of the forearm) and ulna (opposite side of forearm) with open pathologic fractures.

"The latter three patients had lived with their useless extremities for at least one year," Dr Marfuggi noted. "Their arms were functionless, their hands swollen in the 'starfish' manner, and they lived with the constant malodor of necrotic flesh."

So severe was their condition, he said, that these patients usually kept their extremities wrapped in some garment to control odor and unsightliness, only unwrapping for re-injection.

All stage four patients required a below-elbow amputation, followed by stump revision with skin grafting, Dr Marfuggi said. None of these patients was deemed a suitable candidate for prosthetic rehabilitation.

"Frustrating and unrewarding for the clinician," was Dr Marfuggi's assessment of a plastic surgeon's work with drug abusers.

Both Dr Marfuggi and Dr Chiu attributed part of the difficulty to the lack of appreciation of the progression of the disease process among patients.

Sex and drugs combine in 'powerful addiction'

By Harvey McConnell

PHILADELPHIA — Addiction to sex is as powerful as to alcohol and drugs and often the two are combined.

Mark Swartz, DSC, director of workshop programs for the Masters and Johnson Institute, St Louis, Mo, said the institute clinics see an increasing number of people "who need to get high in some way to escape the boredom of their narcissistic life. And the only way they get high is by alcohol, drugs, or sex.

"We are getting hordes of addicts among our homosexual community who will go out and have six flings in an evening, and it is a *bona fide* addiction. The only way they can feel high is when they are doing it, and they have a sense of relief when they do do it.

"Among our heterosexual patients, we have those who think about sex every moment of their working day; they are hyperactive sexually, want it constantly, and have it three or four times a day."

Dr Swartz told the National Conference on Alcoholism and the Family here that alcoholism is probably the biggest cause of sexual dysfunction, but that fact is almost wholly neglected both in the field of sex therapy and the field of alcoholism.

"We have good clinical data on the effects but poor data on innovative teaching for the alcoholic with sexual dysfunction," he added.

Alcohol use for and with sex is not new; the combination increases a woman's arousal but lessens the chance of orgasm, and, in men, increases the desire but lessens the ability to perform.

Sexual dysfunction or fear of poor performance "is enough to drive a man to drink, and it often does. And that's the problem; drinking interferes with sexual performance, and the problem is so common it is probably of epidemic proportions in the United States today."

Dr Swartz said one never knows if sexual dysfunction causes drinking, or drinking causes sexual dysfunction, "and it probably does not matter." Both have to be treated.

One of the most common sexual problems among couples is lack of sexual desire in one of the partners. "Clinically what we get, over and over again, is that one person comes home, has a drink or two, or three, or four, and falls asleep by 10 o'clock. This dims the sexual appetite physiologically, psychologically, and every other way."

Yet there is pressure on the drinking partner to perform and he or she develops a phobia called sexual aversion.

Many alcoholics have difficulty getting close to other people. Lack of closeness and difficulties with the love relationship affect myriad couples. "We must help couples re-establish intimacy and closeness," he added.

And abstinence and sex therapy must go hand in hand, he said.

Dr Swartz said that at least 50% of the clinic patients who are involved in incest — which is a much greater problem than most realize — are alcoholic as well. In St Louis in 1982, 360 cases of incest were documented "and about 10 times that number were not reported," Dr Swartz estimated.

He added: "Alcohol and incest is a dual addiction: when people drink they commit incest, and when they commit incest they are going to drink."

Alcohol, domestic violence put middle-age men in jail

WASHINGTON — Alcohol abuse and domestic violence are the major reasons middle-aged male, first-time offenders are being sent to prison in the United States.

Department of justice officials, to their surprise, have found that nearly 50% of men who enter prison older than 40 years are first-time offenders; of these, 50% admit they were drinking at the time of their crime.

Patrick Langan, of the bureau of justice statistics, and co-author of the report, said nearly 70% of the middle-aged first offenders were sent to prison for violent crimes —mainly murder, manslaughter, and rape and sexual assault. Many of the men had a history of involvement in domestic violence.

Dr Langan said they had expected to find the habitual criminal offender would be the group most commonly sent to prison in middle age. Instead, they found 47% of middle-aged men sent to prison were first-time offenders.

The fact that a middle-aged man without a criminal record is not likely to be sent to prison unless he commits a serious offence underlines the violence of the crimes the men have committed.

Dr Langan said ways must be found to try and prevent domestic violence, and programs should be devised to deal with the early warning signs of such violence.

BACKGROUNDER

Quebec is holding line on addiction services, treatment hinges on 11 reception centres

MONTREAL — Quebec's health care system has not been immune to cutbacks in government spending. Almost every aspect of the provincial health care system has been affected by financial restrictions. But treatment services for drug and alcohol addiction have survived.

"I think this was the only department in Social Welfare that had no cutbacks for any of its programs," says Irene Langis, counsellor with the Montreal Regional Committee for Alcoholism and Drug Addiction. "This is a victory for us."

Budgets for the province's 11 Centres d'Accueil (reception centres), financed by the government's Social Affairs department, have held firm. The 1983-84 budget of $15 million is the same as that allocated one year earlier.

Juan Carlos Negrete, MD, director of Montreal General Hospital's Alcohol and Drug Dependency Unit, and a professor of psychiatry at McGill University, agrees.

"Programs have, if anything, been expanded to meet growing needs. It seems to be a protected area. Our alcoholism program, far from being decreased, expanded. We get more help from the rest of the psychiatry department."

While other hospital departments have been streamlined or even closed, Dr Negrete says services offered by his department have grown in response to the medical community's growing awareness of addiction. "More and more physicians are identifying the problem among their patients," he said, "and more and more businesses are developing employee assistance programs."

Not all the news is good. In the past three years, cocaine addiction has grown alarmingly in the Montreal area. Dr Negrete says use of the substance is trickling down from upper-middle income earners to low-income groups, and he notes addicts are beginning to seek assistance voluntarily. Some area Alcoholics Anonymous groups now focus on alcohol abusers who are also cocaine abusers.

A research study aimed at identifying public addiction treatment facilities in the Montreal area is underway by the Montreal Regional Council. Ms Langis, who heads the study, says it should be ready for publication this year.

As Canada's most bilingual city, Montreal is home to a large anglophone as well as francophone citizenry. Addiction treatment facilities vary for each, says Dr Negrete.

Though Montreal General prides itself on its ability to offer comprehensive health care in both official languages, it has chosen to offer programs in its Alcohol and Drug Dependency Unit in English, since alternative treatment facilities for anglophones are comparatively few. While such facilities have increased in number in the French-language community, says Dr Negrete, there has been no corresponding growth in services for anglophones.

Quebec's system of alcohol and drug addiction treatment hinges on the province's 11 Centres d'Accueil. Four of these facilities are located in the Montreal area, the region of the province that experiences the greatest demand for such treatment.

They include: Domremy, founded as a private institution in 1956, and taken over by the Quebec government 20 years later; Alternatives, where group therapy is primarily used in treating drug addicts; Prefontaine, newest of the four Centres d'Accueil, founded in Feb, 1982 as part of a hostel for homeless men; and Le Portage, a centre that focuses on hard drug addicts.

Domremy has an 85-bed residence on Montreal's West Island, augmented by four out-patient centres in north, east, and central Montreal, as well as suburban Laval. The institution treats about 2,000 annually, and is always at full capacity. Those needing residential facilities may have to wait for a bed, though they're urged to use one of the 'satellite' centres in the meantime to "work on motivation." Follow-up treatment is also provided at these facilities, explains Ms Langis.

Prior to government takeover in 1976, treatment at Domremy focused on medical help. Today, non-medical treatment takes precedence, with fewer physicians and nurses involved, but more psychologists, counsellors, social workers, and other therapists. Treatment is offered only in French to men and women over age 18; average age is 45. Domremy's budget is about $3 million per year.

Alternatives opened in 1969 as a largely volunteer-operated crisis intervention centre for hard drug users in Montreal's west end and has retained much of its original philosophy since it came under the government's wing in 1976.

Though most services are external, a small group home handles up to six people. It is staffed around the clock. External centres in the east and west ends serve French and English communities, respectively. Treatment is based mainly on group therapy.

In addition, some 90 volunteers affiliated with Alternatives visit schools and other institutions to discuss problems related to drug addiction.

A key part of Alternatives' service is the access it provides addicts to counsel and support at any time. Those registered with the institution are able to call a volunteer in either French or English at any time of day or night. The institution's annual budget is about $800,000.

Prefontaine's 40-bed facility offers assistance to vagrants whom police recognize as alcoholics or drug abusers. They are given food and shelter, and therapists are available to work on motivation, rehabilitation, and modification.

Written by Gary Lamphier
Reported by Zoe Bieler

"The success rate for this (vagrant) population is almost nil," says Ms Langis. Those who can be helped are later referred to Domremy.

For vagrant women identified as addicts, Prefontaine has a contract with a downtown, private halfway house, Maison de l'Ancre. Here, women who can't live on their own are given temporary help and shelter. Maison de l'Ancre, a private institution, exists mainly on donations, though it receives some public funds from Prefontaine. "It is an example of good collaboration between public and private sectors," says Ms Langis.

Prefontaine's annual budget is about $1.2 million.

Le Portage, a facility for hard drug addicts, has maintained the same methods of rehabilitation it used when founded in the 1960s.

Le Portage has an admission centre in Montreal and an 80-bed residential centre in the Laurentians, where drug addicts spend eight months to one year. Their average age is about 30 years, and many have served prison terms. Treatment is offered in English and French, but Ms Langis says another language is also at work: "Portage really has its own language," she says. "Our residents have developed a sort of Franglais, a language of their own. It is neither French nor English."

Aside from the Centres d'Accueil, Montreal has a number of other treatment facilities for alcohol and drug addiction. Foster, a small, 20-bed residential centre on the south shore, assists both francophone and anglophone Montrealers. Also government-funded are special facilities for addicts in area hospitals such as St Luc, Santa Cabrini, Hotel Dieu, and Montreal General.

The largest of the hospital facilities is at St Luc, where 15 non-medical beds are set aside for detoxification and several medical beds are available for treatment of barbiturate overdoses. The hospital also has a department to investigate liver damage and an out-patient service for industrial workers who are alcoholic.

Santa Cabrini has 13 beds for detoxification, and offers services in French and Italian. Hotel Dieu has out-patient facilities and two beds for detoxification. Montreal General alone offers services in English

The hospital has extensive out-patient services and four designated beds in its psychiatry wing. The shortage of emergency beds is acute; none of the four available beds is ever unused for more than two hours at a time.

Homage to a rehabilitated star

Centre benefits from namesake's renown

Singer/comedian Lapointe: his name helps a lot

MONTREAL — It was 1976, the year the Olympic Games came to Montreal. For the city's residents, the Games brought back the glory that had been missing since Expo '67. It was a time of celebration.

But not for Jean Lapointe. He'd had enough of celebrating. Instead of imbibing, the popular Quebec singer, actor, and comedian admitted himself for treatment at an inconspicuous, private residential institution called Maison Querbes. For the next while, one of Maison Querbes' 12 beds served as Jean Lapointe's home. For, besides being an accomplished entertainer, Jean Lapointe was an alcoholic.

For Jean Lapointe, the interlude was beneficial. His rehabilitation was a success — so successful, in fact, he was later elected to the institution's board of directors.

Maison Querbes' 12 beds eventually proved insufficient to meet the demand for treatment. In 1981, the board and its newly-elected president, Jean Lapointe, decided to move to larger quarters. It found a new home: an 18th-century brick structure that formed part of the convent of the Grey Nuns.

The new institution opened its doors in June, 1982, financed in part by a $200,000 grant from the Quebec government and another $200,000 from Ottawa's Canada Community Development Program. It now has 36 beds (48 by year-end), some with magnificent views of Montreal's harbor and the old Expo '67 site.

The institution also boasts a new name — Maison Jean Lapointe.

"His name helps a lot," says Jacques Perras, director of research for the facility. "He is so well-known and so much loved throughout Quebec." In addition to the weight Mr Lapointe's name adds to public fund-raising campaigns — campaigns in which he actively participates — it is strongly rumored the entertainer was instrumental in securing the grant from the provincial government.

As of year one, it appears the money was well-spent. More than 370 people were admitted to Maison Jean Lapointe during its first 12 months of operation, including more than 200 in the first six months of 1983, says Mr Perras. Most have been men in their 40s, although middle-aged women account for 30% of the total. "But we have more and more people in their 20s applying," Mr Perras adds.

Maison Jean Lapointe is just one of about 45 private treatment centres in Quebec for alcohol and drug abusers, says Irene Langis, counsellor with the Montreal Regional Committee for Alcoholism and Drug Addiction. The Regional Council exercises little control over these institutions, though the provincial government demands the same standards of health and safety as those imposed on nursing homes and day care centres. Treatment procedures, services, fees, and staffing are not closely monitored, she says.

Some private institutions rely largely on volunteers, charging minimal fees for treatment. Others charge $1,000 or more per month for residential treatment.

At Maison Jean Lapointe, residents pay $1,180 for a standard three-week treatment period. While Medicare covers visits and consultations with attending physicians, all other expenses are paid by patients. Some are sent to Maison Jean Lapointe by employers; for these people, the fee is $1,710, with the difference covering additional paper work.

The "social detoxification" process through which patients proceed is uniform. All are required to attend 21, two-hour lectures during their stay. Residents must also attend 15 external AA (Alcoholics Anonymous) meetings, going to different AA chapters each time.

"For 21 days we free our patients from external pressures and take them away from their former life," says Mr Perras. After the first day, even patients' families aren't permitted direct contact.

Following discharge, counsellors pay personal visits to former patients for two months, and continue contact after that by phone. Patients cannot be considered for re-admission for at least one year.

All staff counsellors are rehabilitated alcoholics, says Mr Perras.

"We are also considering a module, or at least special beds, for younger people," says Mr Perras, "but we're not quite ready for this as yet." Other planned changes include a 12-bed section for English-speaking patients. (At present, only French is spoken at Maison Jean Lapointe.)

The centre expects to serve up to 800 patients annually, once it is operating at full steam. But continued service depends largely on support from the federal government's Canada Community Development Program and the province of Quebec.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Canada strives for balance in supply, demand control

The last two paragraphs of the front page article — Canada attains most votes in bid for UN drug seat (**The Journal**, July) seem to give a false impression.

I wanted to stress Canada's support for a *balanced* effort, including measures relating both to demand, and to supply, of illicit drugs. Measures needed to reduce supply are mentioned in detail in your International pages of the same issue of **The Journal.**

In these fields, much further effort has been and will be expended on such programs as rural redevelopment in areas where there is economic dependence on illicit crops, and countering the illicit traffic by all possible means, especially fundamental attacks on the assets of this illicit activity. Canada's support to the United Nations Fund for Drug Abuse Control is evidence of our commitment to these approaches to the supply side of the problem.

But there is also the demand side of the equation which has its strongest economic "pull" effect in developed countries, such as Canada. Here our friends in developing countries, which are the source of some illicit drugs, have pointed out over the past decade that we in developed countries must take action on the demand side, domestically.

At the last session of the commission, (UN Commission on Narcotic Drugs), the Canadian observer delegation indicated what measures were being taken in Canada to reduce illicit demand. As examples, mention was made of the information programs of the department of national health and welfare to discourage the use of marijuana (the brochure *Stay Real*) [**The Journal**, June]; of activities to persuade physicians to prescribe drugs such as benzodiazepines more carefully (therapeutic monographs in *Canadian Medical Association Journal*); information for the public on this topic (*The Effects of Tranquillization: Benzodiazepine Use in Canada*)[**The Journal**, June, 1982]; a resource on women's use of minor tranquillizers and alcohol (*It's just your nerves*), as well as the work of provincial alcohol and drug commissions in this field, especially the Addiction Research Foundation of Ontario.

May I take this opportunity to thank all those who made Canada's election to the UN commission possible — the staff in Canada's department of external affairs around the world, but particularly in New York, Vienna, and Ottawa; friends across Canada in the provinces who have been supportive; and friends of Canada, appreciative of Canada's efforts in the commission over the years, who ensured that Canada's election by the Economic and Social Council of the UN to the Commission on Narcotic Drugs was nearly unanimous.

Donald M. Smith, PhD
Senior Scientist
Intergovernmental and International Affairs
Health and Welfare Canada
Ottawa, Ontario, and
Former chairman
UN Commission on Narcotic Drugs

Smith: nearly unanimous

Parents gain from 'numbers, ideas'

We have been attempting to form parent groups for prevention or reduction of substance abuse among young people in Saskatoon and throughout the province of Saskatchewan.

We believe the government, law enforcers, and schools cannot be expected to solve all the problems of drug abuse by young people. The greatest responsibility lies with the parents. Parents must be made aware of the escalation of drug use and then be encouraged to educate themselves with the most up-to-date information so they can intelligently discuss the subject of drug abuse with their young people.

We are interested in learning of any group of parents organized or attempting to organize toward the prevention and reduction of drug use in young people. Then, perhaps, in strength of numbers and ideas, a parents' federation of drug-free youth might be formed.

Eloise E. Opheim
Chairperson, Drug and Alcohol Committee
Mount Royal Collegiate
Saskatoon, Saskatchewan

Driving course for teens sparks reader's interest

Please send me more information on the Three for the Road program reported in the article, Teen driving course goes to younger viewers, by Mark Kearney (**The Journal**, May).

Patty Stuart Kyllonen,
Coordinator
Community Alcohol and Smoking Prevention Project
Apalachee Community Mental Health Services
Tallahachee, Florida

(Ed Note: An information package is on its way. Other readers interested in more information may write to: Alan M. Marcus, PhD, Consulting Psychologist, Human and Social Systems Research and Development Branch, Ministry of Transportation and Communications, 1201 Wilson Ave, Downsview, ON M3M 1J8.

TJ is valuable source of info

We find your publication, **The Journal**, a valuable source of information in our work and look forward to receiving it.

Kathleen A. Caldwell
Northlands Centre
Derry City
Ireland

The Journal **welcomes Letters to the Editor. Letters bearing the full name and address of sender may be sent to:** The Journal, **33 Russell St, Toronto Canada M5S 2S1.**

Golobitsh

Young smoker: most important target group for prevention

Cig ads hit women—health warnings miss

By Maureen Brosnahan

WINNIPEG — Tobacco companies have been successfully gearing their ad campaigns to the female market for the past 15 years, yet only a small percentage of women are aware of the harmful consequences of smoking, says a Canadian health researcher.

The risk of lung cancer to women smokers is 2½ to five times higher than to non-smoking women, Mary Jane Ashley, MD, told the Fifth World Conference on Smoking and Health here. Dr Ashley is professor and chairman of the department of preventive medicine and biostatistics, faculty of medicine, University of Toronto.

She added that the risk of heart problems among heavily smoking women who use oral contraceptives is 39 times greater than in non-smokers. Smoking during pregnancy also increases the risk of miscarriage and still-births.

But, she said, a 1981 study found "serious gaps" in consumers' knowledge about these risks.

Ashley: risks

"For example, nearly 50% of all women did not know that smoking during pregnancy increases the risk of stillbirth and miscarriage. About 30% did not know about the relationship between smoking, oral contraceptives, and the increased risk of heart attack," she said.

Joanne Luoto, MD, director of the office of smoking and health in the United States department of health, said more than $1.5 billion is spent on promoting smoking in the US. In 1980, $83 million went toward ads in women's magazines alone.

Dr Luoto said the ads are having some effect. In one case, a company promoted their satin-wrapped filter cigarettes by offering a free silver case. Within 13 days, 1.3 million people responded.

"Further renewed efforts are needed," to curb the effects of advertising, she said.

Dr Luoto said the growth of the smoking habit is a phenomena of the early- to mid-20th century. "It's newer than the automobile, the airplane, and the telephone," she said.

Earlier, Monique Begin, Canada's health minister, told the 1,000 delegates the "most-important target group" for anti-smoking campaigns is "young women and young pregnant women."

She said while smoking among all women is beginning to decline, the rate among young women is rising.

Ms Begin said: "While some women have quit, the rate of smoking among teenage girls increased by 35% during the 1960s and early 1970s."

Begin: targets

Ms Begin added that the rate of smoking among women 15 to 24 years of age also rose above that of men for the first time.

Later in the conference, Bobbie Jacobson, MD, author of the anti-smoking book *The Lady Killers* (**The Journal**, Aug, 1981), called on the women's movement to focus its attention on battling health hazards associated with smoking.

Jacobson: taboos

Dr Jacobson said over the years, feminist organizations have focused attention on issues such as abortion and repealing restrictive legislation but have not done enough to combat rising smoking rates among women.

Dr Jacobson said women are smoking more because taboos against women smoking in public have diminished, and advertisers have taken up the campaign to promote the smoking woman as liberated and glamorous.

Anderson

Pregnant women: 50% don't know

'Verbal agreements not enough'

Canada needs tough anti-smoke laws

By Maureen Brosnahan

WINNIPEG — Delegates to the Fifth World Conference on Smoking and Health here have called on the federal government to introduce legislation banning all tobacco advertising throughout Canada.

A telex sent to federal Health Minister Monique Begin signed by conference chairman David Nostbakken, PhD, also called for the establishment of smoke-free work environments for federal employees, and revision and enforcement of the federal law which prohibits the sale of tobacco products to minors.

George Piper, MD, president of the Canadian Council on Smoking and Health added a warning to the government against relying on voluntary agreements with the Canadian Tobacco Manufacturers' Council, "which is unlikely to regulate its own industry to the detriment of its corporate well-being."

During the conference, Ms Begin told delegates she had managed to secure a number of promises from the tobacco industry with respect to advertising and promotion of tobacco products and she said she is optimistic such agreements can continue to be made.

But Kurt Baumgartner, secretary-general of the conference, said voluntary agreements aren't enough.

Legislation is necessary, he said. "This is a Canadian story, where the Canadian government will never do anything with regard to legislation over smoking." He added that the government has too much to lose in tax revenue if the industry rebels against it.

Baumgartner: too much to lose

Dr Piper said he intends to see that the government treats the recommendations seriously. "I intend to see that they're not left on the back burner. If we have to get everyone to write to the Prime Minister or their member of parliament, then we'll do that."

The delegates also supported a total of 38 recommendations aimed at reducing smoking-related diseases and encouraging further public education programs outlining the dangers of smoking.

Many of the recommendations were aimed at reducing smoking among young women and among those in developing countries where delegates were told tobacco companies are now focusing their attention. (See The Back Page.)

Among the other recommendations presented were:

- a ban on world-wide production and export of cigarettes with a tar yield of more than 20 mg;
- mandatory health warnings on all tobacco products sold around the world;
- increased support of the anti-smoking movement by world religious leaders;
- the formation of national smoking control groups in all countries by 1987;
- a call for health ministers around the world to present anti-smoking progress reports to the next world conference scheduled for 1987 in Kitakyushu, Japan;
- an increase in funding from international organizations such as the World Health Organization (WHO), for smoking control efforts; and
- stronger participation by women's health groups in the war against tobacco products.

During the six days, an estimated 300 presentations were made at various sessions by smoking and health experts from around the world.

The $650,000 conference was sponsored by the Canadian Cancer Society, the Canadian Lung Association, the Canadian Heart Foundation, the federal government, and the American Cancer Society.

As well, international agencies such as the Canadian International Development Agency, the Swedish International Development Agency, and the Norwegian International Development Agency contributed about $75,000 to help subsidize the travel and expenses of approximately 100 delegates who came to the conference from developing countries.

During the conference, Samuel Hynd, MD, Swaziland's minister of health (**The Journal**, Aug) called cigarettes "a slow, sinister, suicidal drug" which is now infiltrating developing countries.

"Why must we wait until the crisis in our developing countries becomes of such catastrophic proportions before we do something about it?" he asked.

Roberto Masironi, MD, chairman of the WHO's smoking and health program, urged the delegates to fight off the pressures of the tobacco companies. "The major tobacco companies in the world have set their sights on developing countries," he said, adding that many Third World countries are countering this by bringing in smoking control programs.

Sir George Godber, Britain's former chief medical officer and a retired WHO board member, called for "a world where smoking continues only among consenting adults in private."

He labelled smoking as the "largest single avoidable threat to health in the world today" and the cigarette "the most lethal weapon created by man for peace-time use."

NEWS

Mandatory blood tests urged for Ontario drivers

By Mark Kearney

TORONTO — Mandatory blood tests for suspected impaired drivers could be approved for Ontario by the end of the year, says a lawyer with the Attorney General's office.

Bruce Young, chairman of the provincial government's interministry task force on drinking and driving, says a committee of that task force is recommending the blood tests to improve detection of alcohol or other drugs in drivers. He expects the committee to submit its report to government soon.

Breath tests are not always possible, he says, because the drivers are injured or feign injury and are taken to hospital. In some cases when a breath test can't be taken, a driver, although impaired, can't be prosecuted because there is no legal evidence of blood alcohol level.

Furthermore, breath tests can't detect use of drugs such as marijuana, Mr Young told the session on impaired driving and the law at the Cannabis: Consequences for Canadians conference here.

The Canadian Bar Association and the Canadian and Ontario Medical Associations support the mandatory blood tests because of the increasing number of drinking and driving accidents, he says (**The Journal**, Nov, 1982).

Mr Young says the drivers won't necessarily have to consent to taking the test. A law could require motorists, as a condition of securing a licence, to sign a document allowing the blood tests to be taken if they are involved in an accident.

This "implied consent" is already in place in some parts of the United States, he says.

Mr Young told **The Journal** the task force committee has yet to determine who will administer the blood tests and how they will be handled. Currently, doctors don't have the legal right to take blood samples from people injured in car accidents if they are unconscious or refuse.

A law passed by the Saskatchewan legislature in June requires doctors to take blood samples from impaired drivers. The Saskatchewan Medical Association supports the government's intention but is concerned about the possibility that taking the sample may become more important than treating the patient (**The Journal**, March).

The Saskatchewan legislation is expected to be put into full effect this year. Canadian Justice Minister Mark MacGuigan is also considering federal legislation requiring blood alcohol tests for those unable to give a breath sample, usually as a result of unconsciousness.

While there could be difficulties in getting impaired drivers in remote areas of Ontario to a hospital for the tests, Mr Young says that shouldn't prevent the law from working in most cases.

Manitoba seeks blood test law

WINNIPEG — If a provincial government committee has its way, Manitoba's drunk drivers may soon be subject to blood tests. The committee, appointed a year ago by Manitoba Attorney-General Roland Penner, argues in its recent report that breath samples sometimes can't be obtained from those injured in road accidents, nor do breath samples detect drugs other than alcohol.

But the committee is realistic about opposition to its recommendations, admitting its report considers "neither the obvious civil libertarian issues nor the possible defences arising from the Canadian Bill of Rights or the Charter of Rights."

BC considers hike in drinking age

VICTORIA — The British Columbia government is considering raising the drinking age to 21 from 19 years following a recommendation from the BC Medical Association (BCMA).

The BCMA's emergency medical services commission says studies have shown a correlation between the drinking age and traffic accident rates for young drivers. Drivers less than 20 years represented only 9% of all BC drivers, but were involved in 27% of the road fatalities and 32% of all injuries.

Although there was a 30% drop in traffic fatalities across BC last year, the province still has one of the worst road safety records in Canada.

Norman Hamilton, MD, who made the BCMA recommendation, says the province could expect a decrease in the accident rate if the drinking age were raised.

In the early 1970s all provinces and about 30 states in the United States lowered their drinking age. Since then a number of states have realized their mistake, Dr Hamilton says, and raised the drinking age. Night-time fatal accidents dropped by an average of 28%, he says.

In Canada, two provinces, Ontario and Saskatchewan, have raised the drinking age to 19 after lowering it to 18.

Opiate addicts are showing gains with psychotherapy

By Lillian Wylie

NEW YORK — Opiate addicts can benefit from psychotherapy, says a group of scientists from the University of Pennsylvania.

George E. Woody, MD, of the university's Drug Dependence Treatment Unit, and head of the eight-member research team, told the American Psychiatric Association meeting here: "One-third of opiate addicts in our methadone treatment program are both interested in professional psychotherapy and benefiting from it" (**The Journal**, July).

Clinicians have noted the high degree of psychopathology displayed by opiate addicts, Dr Woody said.

"Recent studies indicate the types of psychiatric problems observed in addicts are similar to illnesses which are often treated with psychotherapy when they occur in non-addict populations."

The research team studied the usefulness of psychotherapy for addicts under certain conditions.

"The development of methadone maintenance has provided a means to reduce much of the patient's intense, impulsive, daily search for illicit substances," Dr Woody said. "Stabilization with methadone has permitted the development of therapeutic, long-term relationships."

An opportunity to receive six months' professional psychotherapy in addition to paraprofessional counselling was offered to opiate addicts who were beginning a new treatment episode on a methadone maintenance program. The patients were randomly assigned to 1) drug counselling alone, 2) counselling with supportive-expressive psychotherapy, or 3) counselling plus cognitive-behavioral psychotherapy.

"Sixty per cent of patients meeting the study criteria expressed an interest in the psychotherapy program, and 50% actually became engaged," Dr Woody said. The 110 patients (all male, 18 to 55 years of age) were assigned to one of the three treatment modalities.

"Patients in all three treatment groups improved significantly," Dr Woody reported. "Patients receiving additional psychotherapies improved in more areas and to a greater degree than those who received counselling alone, and with less use of medication."

Top crime fighters join UN drug fund in global battle

By Thomas Land

MILAN — The 'Big Four' international associations concerned with organized crime have formed an alliance with the hard-pressed United Nations Fund for Drug Abuse Control (UNFDAC).

The elite of many institutions dealing with social problems, the Big Four wield great influence and hold an enormous world-wide pool of specialist knowledge. They have joined forces with the UNFDAC in response to mounting evidence of collaboration linking narcotics smugglers, arms traffickers, and political terrorists intent on destablizing Western society.

The Four are the International Association of Penal Law, the International Society for Criminology, the International Society of Social Defence, and the International Penal and Penitentiary Foundation.

The UNFDAC was created 12 years ago to assist member states to combat illicit narcotics cultivation, production, processing, and trafficking. Giuseppe di Gennaro, its executive director, planned to visit Australia where official inquiries have recently shed fresh and disturbing light on global connections linking various branches of organized crime.

Formal agreement for collaboration between the UNFDAC and the Big Four was reached at a special meeting held during the International Congress on Criminal Justice Processes here recently.

It coincided with the arrest of hundreds of suspects in cases involving global narcotics and gun running as well as murder, and allegations of a "blood pact" between the Neopolitan Mafia and the Red Brigade terrorist organization.

Preliminary judicial investigations are to conclude here soon into what is believed to be the world's biggest smuggling organization, which has sent millions of weapons to the Middle East in return for huge quantities of heroin destined for the West.

The UNFDAC supports rural development and crop substitution in the principal opium-producing areas.

It assists medical and educational schemes for the rehabilitation of addicts and the prevention of drug abuse. And, it encourages control measures worldwide to improve the detection of illicit cultivation and to counter trafficking.

The crime prevention associations are most likely to assist the UNFDAC in promoting international cooperation against organized violence. For a start, they are to act as consultants for the UNFDAC, participating in the various forums of its programs.

Young driver fatality rate 'disproportionately large'

ZAGREB — Young people between the ages of 16 and 24 years make up a "disproportionately large" part of the fatalities caused by alcohol-related traffic accidents.

Charles Kaelber, MD, acting director of the division of biometry and epidemiology at the United States National Institute on Alcohol Abuse and Alcoholism says alcohol-related accidents constitute the largest "single cause of death among persons under the age of 35."

Dr Kaelber extracted statistics for the years 1977 to 1981 from the US Fatal Accidents Report System and presented them at the 29th International Institute on the Prevention and Treatment of Alcoholism here.

He said traffic fatalities have averaged 50,000 annually in the US, "resulting in a crude death rate of 22 per 100,000 per year for all ages combined. However, for the 16- to 24-year group, the rate is double this figure, and about "half of all traffic fatalities occurred in persons under the age of 25."

The proportion of alcohol-related fatal accidents has risen to 43.3% in 1981 from 35.3% in 1977 while the 16-to-24-year group accounted for nearly 50% of these deaths, Dr Kaelber said.

Although alcohol involvement in multi-vehicle accidents appears to be less, "the contribution of younger drinking drivers remained substantial," he added.

Dr Kaelber stressed that the data point to the pronounced association between alcohol consumption and fatal crashes "when inexperience in driving and inexperience in drinking converge."

Dr Kaelber presented his data to the newly-established Alcohol and Traffic Safety section of the International Council on Alcohol and Addictions.

Program will be 'action-oriented'

ICAA forms alcohol policy group

ZAGREB — Publication and wide distribution of "relevant and reliable" statistics on alcohol consumption and related problems is among the immediate objectives of the newly created Alcohol Policy section of the International Council on Alcohol and Addictions (ICAA).

Gabriel Romanus, who chaired the first meeting, told **The Journal** the section will bring together scientists, administrators, and policymakers in an "action-oriented program aimed at preventing the harmful effects of alcohol consumption."

Mr Romanus, director of the System Bolaget (liquor monopoly) of Sweden, said discussions here during the 29th International Institute on the Prevention and Treatment of Alcoholism touched on broad policy issues as well as specific questions such as home distilling, exports, and the closing of liquor stores on weekends.

Discussions have been held with the World Health Organization to accumulate statistics from different countries. In addition, the section will generate and encourage papers on all aspects of alcohol policy including such topics as: the duty-free sale of alcohol, participation by state alcohol monopolies in public health programs, advertising, early recognition of alcohol problems, the sale and marketing of alcohol in the Third World, and the economic aspects of the alcohol industry.

Some of the accumulated data will be presented to the 30th International Institute on the Prevention and Treatment of Alcoholism, in Cannes, France in 1984.

NEWS

Pragmatism eclipses rehab in corrections system

By Betty Lou Lee

HAMILTON — The corrections system is giving up on rehabilitation in favor of pragmatism: If it works, we'll keep it; if not, we'll try to get rid of it.

That's the assessment of Donald Evans, executive director of the community programs division, Ontario ministry of correctional services.

"There has been a collapse, if not the demise of the rehabilitation ideal. The whole concept has received enormous criticism from both the right and left," he told the 24th annual Institute on Addiction Studies here.

"There's a lot of tension in the system, with no clear-cut ideology."

He said attempts to control substance abuse exemplify the confusion around social service, rehabilitation, and punishment.

"Prohibition is no longer feasible, so maybe we can raise the drinking age. The result is that more people are criminalized, but that doesn't solve the problem. They don't stop drinking.

"We have given up on social services, rehabilitation, and help, so can we control the problem? With alcohol and drugs, do we have crime or health problems? If we decriminalize behavior, maybe the health problems are amenable to treatment," Mr Evans said.

The number of people on probation in Ontario has grown from 10,000 to 36,000 in the past decade, with another 6,000 in correctional institutions.

This has led to the myth that all the dangerous people are in prison, and the non-dangerous ones are in the community, Mr Evans said.

But when most judges decide on sentences, "if they look at the offence, they tend to incarcerate. If they look at the personality, they are most likely to give community supervision."

The corrections system is self-regulating, Mr Evans said. If the community perceives sentences to be too lenient, sentences get longer, but fewer people receive them.

If the community believes sentences are too harsh, they will get shorter, but more people will receive them, and prison occupancy rates remain about the same.

Abuser's family needs treatment too: Schneider

PHILADELPHIA — A focus on treating family illness is the trump card if progress is to be made against chemical dependency, believes Max Schneider, MD, vice-president of the American Medical Society on Alcoholism.

Dr Schneider, a clinical instructor at the School of Medicine, University of California at Irvine, and director of Recovery Services, St Joseph's Hospital, Orange, Cal, said the user of drugs is sick, but so are those living with him or her.

While it's important to get the user into treatment, "I can tell you what will happen if the family doesn't get into treatment too; they will go on and get sicker and sicker," he said at the National Conference on Alcoholism and the Family here.

Dr Schneider added: "It is totally useless for me as a doctor to sit behind my desk and hand out prescriptions or, as I call them, 'therapeutic sentences,' to the victims of alcohol or drug misuse or abuse in front of me, without involving their families. And frequently the family may be sicker than the user."

Anti-smoke probe evaluates therapy

OTTAWA — Ian McDowell, PhD, of the University of Ottawa has received an Ontario ministry of health grant of $9,768 to evaluate three types of therapy to help people stop smoking.

Dr McDowell, of the university's department of epidemiology and community medicine, will try to determine which method — individual counselling, group education, or group behavior therapy — is most effective for each type of smoker.

The most appropriate educational material for use in family practice will also be identified.

Dr McDowell's grant is one of several ministry awards totalling $508,689 for health research in Ottawa.

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Subject heading: Alcohol and the family, trigger film.

Details: 8 min, 16mm, color.

Synopsis: Foster Brooks, "the lovable lush," comes into a bar. After a couple of drinks, he tells the bartender that he and his wife are probably splitting up. He says they have tried everything but her drinking is out of hand. Suddenly, Foster asks the time and, when he is told that it is 9:30 pm, he gets very upset. Tonight is their 31st anniversary and he had planned to get home on time. He starts to leave, but returns to tell the bartender that he has lied about his wife; she never drinks; she will be waiting anxiously for him because she knows his drinking is a problem. He leaves the bar, forgetting the flowers on the counter. Foster Brooks re-enters to tell the audience that he has played the drunk for many years, but in real life — never again.

General Evaluation: Good to very good. (4.7) This well-produced film had tremendous emotional impact.

Recommended use: With a resource person to help the audience cope with the emotions produced by this film, it would benefit adult audiences, families, and health professionals.

Over the Counter Drugs: Smooth Talk and Small Print

Number: 569.

Subject heading: Over-the-counter drugs, attitudes and values.

Details: 20 min, 16mm, color.

Synopsis: A man with a cold comes into a pharmacy to buy some cold tablets. The pharmacist tries to dissuade him as that particular remedy is inappropriate. After the man leaves, the pharmacist explains why it is so important to understand what you are taking and why. Many drugs have bad side effects. They can contain extra ingredients that seem impressive when advertised on television but can, in reality, be unnecessary or even do harm. He cautions the viewer about misuse of ASA, cold remedies, laxatives, and sleeping pills; he recommends reading labels carefully and questioning doctors and pharmacists.

General Evaluation: Good to very good (4.5). This contemporary, well-produced film was judged a good teaching aid. General broadcast was recommended.

Recommended use: Of benefit to all audiences.

Taking Charge

Number: 570.

Subject heading: Employee assistance programs (EAPs).

Details: 28 min, 16 mm, color.

Synopsis: This film illustrates procedures for a supervisor when an employee's work performance needs improvement. Jan, an extremely efficient secretary gets angry and abusive when under stress; Phil's work has deteriorated and he is taking a lot of time off to the detriment of his division; Charles, in upper-level management, seems to be unable to delegate, and treats his workers abruptly. For each case the supervisor is urged to use a checklist to document work performance and use this documentation in the confrontation interview. Methods of handling the interview are also illustrated.

General evaluation: Poor (2.2). While the case studies were fairly well-handled, the narrator who pointed out the issues was judged to be boring and seemed to be promoting a specific but unspecified "checklist." There was no empathy with the employees nor any suggestion that the procedure was helpful.

Recommended use: With a resource person, could be used in employee assistance program training.

One Way Street

Number: 571.

Subject heading: Alcohol and the family.

Details: 12 min, black and white.

Synopsis: Through constantly changing line drawings we see different scenes including a man going about his daily work, and drinking in a bar with friends. While drinking he appears jovial, but at home he is a different person, beating his wife and little girl. As the years pass, this behavior continues and now his daughter is drinking. She works in a cocktail lounge, and continues to drink. She becomes a stripper and a prostitute, and continues to drink. Through all this, the mother sadly watches out her window or rocks in her rocking chair. (This film has no dialogue, but is accompanied by music).

General evaluation: Poor to fair (2.5). While artistically well done, with strong emotional impact, this film was considered to be full of stereotypes.

Recommended use: With a resource person, this film could be used by families in treatment settings.

DEPARTMENT

New Books by RON HALL

The Strange Career of Marijuana: Politics and Ideology of Drug Control in America

. . . by Jerome L. Himmelstein

Changes in the marijuana laws and in public conceptions of the drug in the United States are examined and the author discusses the role of ideas in the shaping of law and public policy. Existing explanations of marijuana laws are examined and attention is focused on the issue of marijuana ideology: the contexts in which the drug and the law have been publicly discussed. The author argues that both accounts of the Marijuana Tax Act are wrong and he re-evaluates how the changing social status of marijuana users brought about marijuana law reform. Changes in the image of marijuana in public discussion and the terms in which marijuana laws have been discussed are traced.

(Greenwood Press, 88 Post Rd W, PO Box 5007, Westport, CT 06881. 1983. 179p. $27.95. ISBN 0-313-23517-1)

Alcoholism and Homosexuality

. . . edited by Thomas O. Ziebold and John E. Mongeon

This reprinted issue of the *Journal of Homosexuality* provides an overview of the clinical problems and treatment options for gay men and women with problems of alcoholism. New approaches that are being implemented in services for the group are analyzed, and programs and treatment protocols that have had reasonable measures of success are described. The first paper analyzes the assumptions underlying the biological and genetic approaches, learning theory, psychoanalytic perspectives, and sociological models as they relate to alcoholism and homosexuality. A description of the format of in-service training provided for staff at one agency and the results of the training are presented in a second paper. Other papers are devoted to counselling, specific approaches and techniques in treatment, the description of an alcohol treatment program, Alcoholics Anonymous, and prevention.

(Haworth Press, 28 E 22nd St, New York, NY 10010. 1982. 117p. $20. ISBN 0-917724-93-2)

Alcohol and Reproduction: A Bibliography

. . . compiled by Ernest L. Abel

This bibliography contains references to material dealing with alcohol's effects on reproduction. It includes entries dealing with sexual behavior, sexual function, and sexual physiology. Entries are arranged alphabetically by author and are numbered consecutively. A subject index provides access to the 2,120 citations.

(Greenwood Press, PO Box 5007, 88 Post Rd W, Westport, CT 06881. 1982, 219p. $29.95. ISBN 0-313-23474-4)

Other books

Mental Health Services in Transition: A Policy Sourcebook — Vallance, Theodore, R. and Sabre, Ru M. (eds). Human Sciences Press, New York, 1982. Historical background; community mental health centre; human services delivery in the context of politics and tradition; prospectives. Index, references. 304 p. Human Sciences Press, 72 5th Ave, NY, NY 10011. $29.95. ISBN 0-87705-700-1.

Drinking in America: A History — Lender, Mark Edward and Martin, James Kirby. Free Press, New York, 1982. Drinking in early America; sources and strengths of the temperance movement; decline of temperance; drinking in modern United States. Index, illustrations. 222 p. Free Press, 866 3rd Ave, NY, NY 10022. $19.95. ISBN 0-02-918530-0.

Beliefs and Self-Help: Cross-cultural Perspectives and Approaches — Weber, George H. and Cohen, Lucy M. (eds). Human Sciences Press, New York, 1982. Self-help and beliefs; studies of self-help groups drawn from South Africa, Mexico, the Soviet Union, and the United States; community organization and self-help; self-help groups and advocacy; cross-ethnic comparisons. Index. 359 p. Human Sciences Press, 72 5th Ave, NY, NY 10011. ISBN 0-89885-032-0.

Clinical Management of Poisoning and Drug Overdose — Haddad, Lester M. and Winchester, James F. W.B. Saunders, Toronto, 1983. Emergency management of poisoning; principles of pharmacology for the clinician; CNS disturbances; cardiac disturbances; acid-base disorders; injury to the eye; renal considerations; brain death; natural and environmental toxins; centrally active agents; analgesics; metals and inorganic agents; pesticides; inhalation poisoning and solvents; cardiovascular and hematologic agents. Index. 1,012 p. W.B. Saunders Company, 1 Goldthorne Ave, Toronto, ON M8Z 5T9. $97.50. ISBN 0-7216-4447-3.

Roadside Surveys: Proceedings of the Satellite Conference to the 8th International Conference on Alcohol, Drugs and Traffic Safety, June 23-25, 1980. Valverius, Milan R. (ed). Swedish Council for Information on Alcohol and Other Drugs, Stockholm, 1982. Surveys in Sweden, New South Wales, South Africa, Northern Ireland, Canada, United States; testing for drugs of abuse. 260 p. Swedish Council for Information on Alcohol and Other Drugs, Box 27302, S-102 54 Stockholm, Sweden. ISBN 91-7278-048-7.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Alcoholism and the Family Workshop — Sept 15-16, Winnipeg, Manitoba. Information: Norma Huggins, Information Area Manager, Alcoholism Foundation of Manitoba, 1031 Portage Ave, Winnipeg, MB R3G 0R8.

Detox Training Program (Non Medical) — Sept 19-23, Oct 17-21, Nov 14-18, Toronto, Ontario. Information: Diane Hobbs, Detox and Rehab Programs, Addiction Research Foundation (ARF), 33 Russell St, Toronto, ON M5S 2S1.

Alcohol and Drug Abuse Conference — Sept 27-28, Saskatoon, Saskatchewan. Information: CME office, University of Saskatchewan, 408 Ellis Hall, Saskatoon, SK S7N 0W0.

3rd Annual Meeting of the Canadian Psychiatric Association — Sept 28-30, Ottawa, Ontario. Information: Canadian Psychiatric Association, Ste 103, 225 Lisgar, Ottawa, ON K2P 0C6.

Addictions '83 International — Oct 12-14, Ottawa, Ontario. Information: Mrs C. Cashman, Coordinator, Postgraduate Board, Royal Ottawa Hospital, 1145 Carling Ave, Ottawa, ON K1Z 7K4.

Managing the Information Function — A Joint Annual Conference of Substance Abuse Librarians and Information Specialists, Librarians and Information Specialists in Addictions — Oct 18-21, Toronto, Ontario. Information: Ron Hall, Information and Promotion, ARF, 33 Russell St, Toronto, ON M5S 2S1.

Behavioural Interventions Course — Nov 14-16, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Workshops 1983-84: Employee Assistance Program Management Update — Feb 22-24, 1984, Toronto, Ontario. Information: Yvonne Johns, department head, department of Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

1984 Canadian Addictions Foundation Atlantic Regional Conference, Families and Drug Dependencies New Problems, New Challenges — Apr 29-May 3, 1984, Halifax, Nova Scotia. Information: Nova Scotia Commission on Drug Dependency, 5668 South St, Halifax, NS B3J 1A6.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: Mr J. Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th Fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

Drugs in the Workplace: "A Man-Made Disaster" — Sept 19-20, Alexandria, Virginia. Information: Lee Dogoloff, American Council for Drug Education, 6193 Executive Blvd, Rockville, Maryland 20852.

6th Annual Current Concerns in Adolescent Medicine, Growth Disorders in Adolescence, Threats to Adolescent Health — Sept 22-23, New York, NY. Information: Ann J. Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

2nd Annual Conference of the National Federation of Parents for Drug-Free Youth — Sept 26-28, Washington, DC. Information: National Federation of Parents for Drug-Free Youth, 1820 Franwall Ave, Ste 16, Silver Spring, Maryland 20902.

National Youth Workers Conference — Sept 26-29, Chicago, Illinois. Information: The National Youth Work Alliance, 1346 Connecticut Ave NW, Washington, DC 20036.

Health and Addictions Conference — Sept 29-Oct 3, New York, New York. Information: Dan Barmettler, Institute for Integral Development, PO Box 2172-L, Colorado Springs, Colorado 80901.

American Association for Automotive Medicine (AAAM) 27th Annual Conference — Oct 3-5, San Antonio, Texas. Information: American Association for Automotive Medicine, 40 2nd Ave, Arlington Heights, Illinois 60005.

12th Annual ALMACA Meeting — Oct 3-7, Minneapolis, Minnesota. Information: ALMACA, 1800 N Kent St, Ste 907, Rosslyn, Virginia 22209.

Treating Cocaine Dependence — Oct 6-7, San Francisco, California. Information: Lee Dogoloff, American Council for Drug Education, 6193 Executive Blvd, Rockville, Maryland 20852, or Joan Zweben, Pacific Institute for Clinical Training, Education and Consultation, 714 Spruce St, Berkeley, CA 94707.

Interdisciplinary Approaches to the Issues of the Chemically Dependent Nurse: Areas of Cooperation and Conflict — Oct 15-16, San Francisco, California. Information: Stephanie Ross, Haight-Ashbury Training and Education Project, 409 Clayton St, San Francisco, CA 94117.

Alcoholism in the Black Community: 4th Annual Conference — Oct 29, Newark, New Jersey. Information: ABC c/o RAFT, East Orange General Hospital, 300 Central Ave, East Orange, NJ 07019.

3rd Annual Primary Prevention Conference "Kid's Stuff II" — Nov 1-3, Austin, Texas. Information: Peggy Frias-Lynch Prevention Services, Texas Commission on Alcoholism, 201 E 14th St, 8th fl, Austin, TX 78701.

American Society of Criminology 35th Annual Meeting — Nov 9-12, Denver, Colorado. Information: Joseph E. Scott, department of Sociology, Ohio State University, Columbus, Ohio 43210.

ADPA 1983 Western Regional Conference — Nov 13-16, Los Angeles, California. Information: Eric Scharf, ADPA, 1101-15th St. NW, Ste 204, Washington, DC 20005.

Mental Health Section and Forum on Drug and Alcohol Problems, of the American Public Health Association, Annual Meeting — Nov 13-17, Dallas, Texas. Information: Dr David Duncan, Mental Health Membership Chairman, Southern Illinois University, department of Health and Education, Carbondale, Illinois 62901.

2nd Annual National Conference on Alcoholism and the Family, Western Edition — Nov 20-23, San Diego, California. Information: Fam-Con West II, PO Box C 19051, Seattle, Washington 98109.

The Third Annual New England Conference on Alcohol Issues, "Trends in Policy and Planning for Alcohol Issues" — Nov 30-Dec 2, Newport, Rhode Island. Information: New England Conference on Alcohol Issues, 755 Boylston St, Ste 306, Boston, Massachusetts 02116.

SECAD/8, Southeastern Conference on Alcohol and Drug Abuse — Nov 30-Dec 4, Atlanta, Georgia. Information: Barbara D. Turner, Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, GA 30342.

Abroad

International Conference on Alcoholism — Sept 26-30, Reykjavik, Iceland. Information: International Council on Alcohol and Addictions (ICAA) Case postale 140, 1001 Lausanne, Switzerland.

International Association for Accident and Traffic Medicine (IAATM), 9th International Conference — Sept 27-30, Mexico City, Mexico. Information: Rune Andreasson, Executive Director, IAATM, Karlavagan 119, PO Box 10043, S-100 55, Stockholm, Sweden.

13th International Institute on the Prevention and Treatment of Drug Dependence — Oct 10-14, Oslo, Norway. Information: ICAA, Case postale 140, 1001 Lausanne, Switzerland.

International Drug Conference — Institute — Oct 24-31, Cancun, Mexico. Information: Edward B. Morley, III, Director, Group Travel, Morley Incentives, PO Box 1908, Saginaw, Michigan 48605.

Currents in Alcohol Research and the Prevention of Alcohol Problems — Nov 7-9, Lausanne, Switzerland. Information: Swiss Institute for the Prevention of Alcohol Problems — (SFA/ISPA), PO Box 1063, CH-1001 Lausanne, Switzerland.

4e Colloque national sur la prevention de l'alcoolisme. L'Etat face a l'alcool et aux droques — 10-11 novembre, Lausanne, Suisse. Information: Institut Suisse de prophylaxie de l'alcoolisme, Case postale 1063, 1001 Lausanne, Suisse.

9th International Conference on Alcohol, Drugs and Traffic Safety — Nov 13-18, San Juan, Puerto Rico. Information: T-83 Secretariat, GPO Box 5067, Medical Sciences Campus, San Juan, Puerto Rico 00936.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

2nd International Congress on Drugs and Alcohol — Dec 18-22, Tel Aviv, Israel. Information: Congress Secretariat: Peltours Ltd, Congress department, PO Box 394, Tel Aviv, 61003 Israel.

An International Conference on Alcoholism and Drug Addiction — Apr 2-7, 1984, Canterbury, England. Information: Conference Secretary, Broadway Lodge, Oldmixon Rd, Weston-super-Mare, Avon, BS24 9NN, England.

Third World future is bleak

Politics, profits hinder war on tobacco

By Mark Kearney

WINNIPEG — Various government and health officials from around the world have declared "war" on the tobacco industry's attempt to expand into the Third World.

Several delegates to the Fifth World Conference on Smoking and Health here expressed outrage at the industry for exploiting the health of citizens and creating a smoking epidemic in developing nations.

Abdul Rahman Al-Awadi, MD, chairman of the World Health Organization (WHO) committee on smoking control strategies in developing countries, labelled the tobacco corporations a "highly sophisticated and ruthless industry." By expanding to Third World markets, the tobacco companies are condemning future generations to a vast array of unnecessary and preventable diseases, he said.

"Unless action is taken now, the prospects for the future are bleak," said Dr Al-Awadi, also Minister of Public Health, Kuwait.

A summary of his committee's report says the tobacco industry is "adding the burden of already-increasing rates of coronary heart disease and other smoking-related diseases to the existing problems of malnutrition and communicable diseases.

"In developing countries, the situation is extremely serious because the public is not aware of the dangers to the same extent, nor are educational, legislative, and other measures being taken to combat the smoking epidemic."

The WHO committee is trying to change this, Dr Al-Awadi said, by recommending a number of measures to hinder the tobacco industry in the Third World. Among the recommendations are:

- a ban on all tobacco advertising and sales promotion in developing nations;
- a maintaining of the status quo in developing countries where no tobacco industry exists. Where such an industry does exist, efforts should be made to reduce its role in the national economy;
- a study of optional crops on land which is now being used to cultivate tobacco;
- an end to the double standard by which cigarette brands that carry health warnings in developed countries are sold without these warnings and with much higher tar content in developing nations; and,
- a request that the WHO not engage in discussions with the international tobacco industry until the latter "publicly accepts the scientific fact that smoking is a major, avoidable cause of death and disease."

While a stated strategy is an important first step, a number of delegates expressed concern that problems peculiar to the Third World will make the war against the tobacco industry more difficult there than in the developed countries.

Martin Khor, the research director of the Consumers' Association of Penang, in Malaysia, said one problem is the lack of anti-smoking groups in most developing countries. This has led to a lower awareness among people there of the extent of the problem.

Third World: looking to the industrialized world to act as an example

More than one million people die annually because of smoking-related disease and the Third World, which accounts for 52% of world tobacco consumption, is making up a rapidly increasing proportion of those deaths.

Many developing countries are dependent on the taxes derived from tobacco, Mr Khor said, much more so than industrialized nations. The tobacco industry has entrenched itself with many small farmers, making it politically sensitive for Third World governments to undertake anti-smoking efforts, he added.

Third World governments also lack responsiveness to citizen groups' demands. In many developing countries, the kind of activist demonstration taken for granted in industrialized nations is illegal, Mr Khor said.

Nevertheless, he remains confident the problems can be overcome with strong international cooperation in such things as legislation, public education programs, and crop substitution schemes. His association has made progress in Malaysia with limited resources and "if there are sufficient individuals who are dedicated then it can be done" on a larger scale, Mr Khor told **The Journal**.

Convincing the small farmer to substitute some other crop for the profitable tobacco plant will be difficult, he admitted, but there have been other successful substitutions in the past.

Opium poppies have been outlawed through international cooperation and such a policy can be followed for tobacco. More people are dying in the Third World from tobacco than from heroin, he said.

"We have to create the atmosphere that sees smoking as illegal," Mr Khor said.

The developed countries must also play a stronger role in bringing about these changes in the Third World, he added. Health officials and concerned citizens must pressure their own governments to ensure that export of high tar cigarettes is stopped.

Kjell Bjartveit, MD, an adviser to the WHO from Norway, agrees the problems facing the Third World should be the greatest concern to anti-smoking activists everywhere.

Politicians and the media have to be sensitized to the magnitude of the smoking problem throughout the world, Dr Bjartveit said. More politicians are becoming attuned to these concerns which will help create "a resistance movement" against the tobacco industry.

But it's essential the industrialized world act as an example to the developing countries, Dr Bjartveit told **The Journal**.

"The authorities in the Third World often look to the industrialized world for examples to follow. Our responsibility goes beyond our own borders; our lack of action has repercussions in the Third World."

While a number of delegates spoke passionately about the problems of the Third World, the question remains as to how the passion can be transformed into action.

Mr Khor said there have been some successes in Malaysia by only a relatively small number of concerned health and consumer officials; there's no reason it can't be continued with international help.

He points to the Pesticides Action Network (PAN) as an example of how international cooperation can work. The PAN was set up last year because of increasing concern that multinational companies were dumping into the Third World drugs and pesticides that had been banned or restricted in developed countries.

"It is obvious that a similar grouping should be set up to combat tobacco and smoking, particularly the spread of tobacco to the Third World," he said.

But even if such a group were formed there are still political obstacles to overcome. As some delegates pointed out at the conference, health ministers in Third World countries often wield less power than their finance or economic counterparts.

The health officials argue that despite the short-term economic gains made from tobacco, it creates sickness and death, uses up land where food can be grown, and indirectly causes the destruction of forests because thousands of hectares of trees are felled so that the wood can be used for curing.

Nevertheless, tobacco remains a valuable cash crop. A recent issue of *Ceres*, the journal of the United Nations Food and Agricultural Association (FAO) says: "Tobacco is, in fact, one commodity in which even smaller developing countries can find immediate, tangible, social and economic benefits" (**The Journal**, June).

Dr Al-Awadi said, however, that the FAO is more in favor of battling the tobacco industry than most people believe. He told **The Journal** the FAO is supporting crop replacement programs and coming to agreement with the WHO.

If the UN organizations can and are reaching some agreement, there is still the difficulty of convincing individual governments to turn their backs on the profits of today for the health and safety of tomorrow.

Masironi: high time

Roberto Masironi, MD, coordinator of the WHO program on smoking and health says it's "high time governments fulfill their responsibilities for the health of people.

"The tobacco industry is a trans-national enterprise. This is why it is so powerful. The health enterprise must therefore also be trans-national . . . In spite of all the differences that may exist between countries, the cigarette is a common factor, unfortunately a factor of addiction and disease.

"Why shouldn't governments switch their emphasis from the perpetuation of a harmful habit to the elimination of it?" Dr Masironi asked.

Khor: it can be done

Al-Awadi: public unaware

Bjartveit: set example

THE BACK PAGE

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The Journal

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Turner takes issue with critics

US steadfast on paraquat for domestic pot

By Harvey McConnell

WASHINGTON — Paraquat spraying of marijuana crops in the United States will be pushed by President Ronald Reagan's administration despite legal efforts to get it stopped.

Carlton Turner, PhD, director of the White House Drug Abuse Policy Office, told **The Journal**: "If we don't tackle eradication in this country and demonstrate to the western world we want to do something about drugs, we are not going to turn the tide.

"People forget the perception in the rest of the world that we have an insatiable desire for drugs, that we have no political will to control it, and it is our problem, not theirs."

Congress and the administration are also pushing for paraquat spraying by the Colombian government against illegal marijuana crops there.

Dr Turner, who recently returned from a private trip to South America, noted that US farmers use an estimated 4 million lbs of paraquat a year, over an estimated 10.7 million acres of land, "and nobody gets upset. But let us use less than a pound and a half on less than 2.5 acres, and we get an injunction.

"The issue is not paraquat, the issue is marijuana, but they are trying to hide it with paraquat. It is all right for us to spray paraquat as long as we don't fool with grass."

Dr Turner noted that the temporary injunctions were filed only at the height of the US cultivation season. "I think that would give the American public and the world public a clue as to why they are being filed."

He hit also at critics who claimed that the government made a "propaganda film" of the spraying to show foreign governments that the US has the will to use paraquat on domestic marijuana cultivation. "If the government films it, it is propaganda, but if NBC, ABC, CBS (US television networks), or cable film it, it is facts."

Following the use of paraquat by the US Drug Enforcement Administration on illegal crops being grown on US forest land, suits were filed by a citizens' group in Georgia, the National Organization for Reform of the Marijuana Laws, the Sierra Club, Friends of the Earth, and the National Coalition Against the Misuse of Pesticides.

The nationwide crackdown on drunk drivers has not produced such protests "but if you put a little pressure on marijuana, some people seem to go berserk."

Dr Turner pointed out it was a responsibility of the US government, as a signatory of the United Nations (UN) Single Convention on Psychotropic Drugs, to eradicate illegal, domestic, drug-producing crops, and the UN has singled out

(See — Colombian — p2)

Women inmates are being over-tranquillized

By Anne Kershaw

OTTAWA — Female prisoners in United States jails are three times more likely to be on tranquillizers or other "mood-altering" drugs than male prisoners, says California medical researcher Nancy Shaw.

Dr Shaw, PhD, says it is common practice to give medication to women prisoners without also providing psychotherapy, and this is out of step with current opinion that psychotropic medication be administered only in connection with other forms of treatment such as group or individual counselling.

While no Canadian statistics are available, this form of medical abuse is reported to be a serious problem in provincial jails for women.

Eleanor McDonald, a spokesperson for the Elizabeth Fry Societies of Canada (a private agency providing assistance to women in trouble with the law), said drug overprescription is one of the most common complaints heard from women while they are in prison.

"Women complain that at the first sign of restlessness, doctors prescribe tranquillizers to calm them down. These reports are too consistent and general to ignore," said Ms McDonald who is director of community education for the Elizabeth Fry Society of Toronto.

"When women say they get hooked on tranquillizers while inside, we have to ask pointed questions about the extent to which doctors treat incarcerated women patients as a bunch of troublesome malcontents who simply need to be tranquillized into passivity."

Dr Shaw, a medical sociologist with the University of California, Oakes College, Santa Cruz, said that in 1978 about 10.5% of females and 3.6% of males were on psychotropic medication, with higher rates documented in short-term holding facilitites. She added that the rate in the New York Metropolitan Correction Centre, for example, was about 15% for men and 58% for women.

Female prisoners: reports are too consistent to ignore

After announcing its plans to reduce dependency on the drugs, the US Bureau of Prisons discovered in a follow-up study in 1982 that while overall use of medication had dropped, women still had consistently higher rates.

This form of medical abuse, generally acknowledged to be symptomatic of discriminatory attitudes to women patients, and a problem in society at large, has been documented even more dramatically in some European prisons.

Constance Holleran, executive director of the International Council of Nurses, says one female prison in Great Britain was recently found to have a prescription rate for tranquillizers 100 times that of male prisons.

Dr Shaw says it's unknown how many of the women who receive such drugs are genuinely in need of them. But, she maintains, although many women in jails and prisons require psychiatric care, the number suffering from psychosis, severe depression, and other acute mental illnesses is generally considered to be small.

Dr Shaw says female inmates are medicated for complaints such as anxiety, nervousness, insomnia, mild depression, or as a "cure for behavioral problems." Some prison physicians even prescribe tranquillizers without doing comprehensive medical evaluations of patients, she adds.

Given the small numbers of

(See — Women — p2)

Canada's commissions should pull together

Issues are national says NFld chairman

By Anne MacLennan

TORONTO — The chief of Canada's youngest provincial commission on alcohol and drug problems believes provinces must act together if they are to achieve positive results locally or nationally.

"Most of the issues facing the provinces are not just provincial, they're national concerns," said Eve Beck, chairman, Alcohol and Drug Dependency Commission of Newfoundland and Labrador.

"And the only way there will be effective change is if they are approached more on a national than a provincial scale," Ms Beck told **The Journal** on a recent visit here.

She said an example of common concerns is the issue of lifestyle advertising of alcohol.

Following a conference on the subject in St John's in the summer — the commission's first major meeting — an advisory committee was set up to help the commission formulate recommendations for legislation.

"I would like to be able to share what comes out of this committee with other commissions to see whether what we're going to recommend to our government fits in with other provinces. If so, would we not be better off to approach the CRTC (the Canadian Radio-Television Telecommunications Commission), or whatever regulatory bodies there are nationally, as a collection of commissions rather than simply as an individual commission addressing the needs of its own province?"

Beck: common concerns

She said provincial consensus on issues should not be the goal of joint action. "That would make the whole exercise impossible.

"I doubt very much whether you could get consensus on any issue from right across the country because the needs and politics are so varied."

Rather, commissions should aim at recognition of common concerns and agreement among some commissions, some of the time, about what action should be taken.

Ms Beck said such agreement would be helpful at both provincial and national levels.

"If a commission approached its own government with the support

(See — Collective — p2)

INSIDE

NEWS

Briefly . . .

Beating the heat

TORONTO — After the hottest summer in 24 years, the burning question arises: 'How did Ontario residents cope with the heat'? 'Elementary,' comes the reply from the province's beer companies. 'They drank a lot.' Ontarians consumed about 1.568 million hectalitres (34.496 million gallons) of beer in June and July, when temperatures in Metro Toronto hit as high as 36 degrees Celsius (97 F). The sales volume represents 9.8% more than that forecast by the breweries before the sweltering summer set in. Other beneficiaries of the heat included ice cream manufacturers and air-conditioning firms.

Teen arcade gamblers

LONDON — Thousands of British children and teenagers are addicted to gambling, says the United Kingdom's National Committee of Gamblers Anonymous (GA). The young people get their highs at the local arcade, playing the slot machines and video games that will net £44 million for government coffers this year alone by way of annual licence fees. Now, GA and local government authorities, under the auspices of the Amusement Arcades Action Group, are pushing for legislation. A proposed bill would limit arcades, set minimum age limits, shorten operating hours, and penalize operators who ignore the regulations.

Prime-time drinking

BOSTON — Cigarettes may have gone up in smoke but booze is flowing more freely than ever on television, says sociologist Warren Breed, following a study of television programming trends in the United States during the past 30 years. Breed, of the Institute for Scientific Analysis, Berkeley, Cal, says the incidence of cigarette smoking on dramatic shows and comedies declined between 1950 and 1982, partly because of the US Surgeon General's 1964 report on the dangers of smoking and the 1971 ban on TV cigarette commercials. But alcohol consumption increased in frequency, appearing an average of eight times each comedy hour and 8.5 times each dramatic hour during 1981-82, up from 1.5 and four appearances, respectively, between 1950 and 1963, he says. The study, funded by the US National Institute on Alcohol Abuse and Alcoholism, involved 24 TV stations and 280.5 hours of programming.

Smoke-free dining

TORONTO — Non-smokers in search of clean air in this city's 2,000 restaurants have a new tool: a guide listing 124 of the 250 Toronto restaurants that have non-smoking areas. The booklet — *Bon Appetit* — will be available at pharmacies, hotels, restaurants, and other public access locations. It was prepared at the behest of the Mayor's Task Force on Voluntary Compliance with Non-Smoking Areas in Toronto, based on information gathered from questionnaires. The guide drew a quick rebuff from Garfield Mahood, director of the Non-Smokers' Rights Association: "The list is too short, and not a serious selection of restaurants for Toronto patrons," he complained to reporters.

'Tough guy' police culture spawns heavy alcohol use

By Gary Lamphier

TORONTO — Alcohol abuse among police officers is probably more widespread than it is among the population at large, claims a spokesman from the Canadian Police College in Ottawa.

Sergeant Gion Bezzola says the "cop culture" encourages excessive drinking, just as it encourages male officers to adopt a macho, "tough guy" image.

"The buddy-buddy camaradarie most often entails alcohol, and most often it's at fairly abusive levels," Sgt Bezzola told **The Journal**. "It seems the job and manhood have gone together with hard, two-fisted drinking."

Though he has no statistics to support his contention, Sgt Bezzola says: "My gut feeling is there is higher alcohol abuse among cops than the average population."

Sgt Bezzola conducted a workshop on Employee Assistance Programs (EAPs) and the public sector (specifically, police) at Input '83, the 5th Biennial Canadian Conference on EAPs and alcohol and addiction problems in the workplace held here.

"The police culture is basically a hard-drinking culture," he said. "When I went into training, we worked hard all week and got drunk on the weekend. Not everybody, but a very high proportion. From my point of view, at or near street level, I think the level of alcoholism is pretty high."

In an effort to deal with abuse among police officers, Sgt Bezzola said the Canadian Police College and several police forces across Canada, including those in Ottawa, Edmonton, and Vancouver, have established their own chapters of Alcoholics Anonymous (AA). An "informal network" of police officers across Canada is also in place to assist those who need help with drinking problems.

"The police network is handling alcohol abuse problems reasonably well, but there is still a way to go," said Sgt Bezzola.

He applauded the work of John Shearer, a psychologist with the Ontario Police College, and Pierre Turgeon, of the Canadian Police College, who are now formulating an EAP for the 6,000-member Metropolitan Toronto Police. The study, the first comprehensive look at social, psychological, and medical problems among police officers on a major Canadian police force, is expected to be completed in December. "I hope the Toronto Police buy it (the EAP)," said Sgt Bezzola.

Chris Southgate, director, monitors and member services, Metropolitan Toronto Police Association, says alcohol abuse is a big problem on the force. "I have stated publicly that 15% of the force has alcohol problems. I didn't go higher than that purposefully, because I didn't want to scare the citizenry out of its pants. But I firmly believe the figure is higher."

Mr Southgate says the department has only reacted in a "disciplinary" way to date in dealing with excessive drinkers. "They've just let the guy flounder. That's why we're trying to get something going. If not for the Association's continuous pushing, no doubt nothing would have been done."

Bezzola: job and manhood

Mr Southgate says the department has now agreed to share the cost of the $25,000 EAP study on a 50/50 basis.

The Detroit Police Department is one of several forces in the United States that have taken steps to assist problem drinkers in uniform. Sergeant Roy St Onge, of the Personnel Affairs Unit, says the department's EAP has achieved an 85% success rate in assisting alcohol abusing police officers. The program, in effect since 1972, was prompted by a recognition that "80% of police officers going to Trial Board (an internal disciplinary body) and getting fired had an underlying alcohol problem.

"The bulk of our problems are still with alcohol. It's the drug of choice, if you will," says Sgt St Onge. However, he notes that there are few "pure alcoholics" coming into the program for treatment or referral. Most are also abusers of licit drugs, such as Valium (diazepam), or Seconal Sodium (secobarbital sodium), he says.

Colombian pot crop smaller: Turner

(from page 1)

paraquat as the herbicide of choice.

Commenting on his trip, Dr Turner said he found some significant changes in Colombia, Peru, and Bolivia since his last visit in March, 1981.

"Talking to friends in Colombia, who are not within government circles, I found a significant awareness of the problems they are having with drugs in their schools and their medical schools as well, and the effect drugs have had on many children of high government officials."

Gang-land slaying among traffickers in some areas has decreased, and, on the north coast of Colombia, the primary growing area, "I saw what in my own mind I believe is less marijuana growing than I thought existed, and I think I am a fairly good judge of that." (Dr Turner was previously director of the US government farm in Mississippi which raised marijuana for legal research purposes.)

The Colombia government's special anti-narcotics unit, which has lost 25 men so far this year, "are fighting some tough battles when they go into an area to chase traffickers out, but they are doing an excellent job."

In Peru, where the major government concern at the moment is terrorist groups, Dr Turner found eradication efforts against coca bush cultivation in the Tinga Maria area are beginning to take shape. The US Agency for International Development has initiated crop substitution programs which are well managed.

Dr Turner said the Peruvian government is considering both chemical and mechanical means for eradicating the coca bush. In both Colombia and Peru, terrorist groups have been linked with drug trafficking.

As for Bolivia, "the threat of government change is always on one's mind when one looks at history, but the present government is certainly concerned about narcotic trafficking. It looks a heck of a lot better than it has been, but not as good as I think it will be."

Dr Turner added that the US ambassadors to both Peru and Bolivia assign a high priority to narcotic control in dealings with the respective governments.

Women in jail: 23% are addicted

(from page 1)

women reportedly in need of intense psychiatric treatment, reports of such liberal prescription practices in prisons "and the serious medical implications of such drugs" point to the need for more research on prescribing patterns and procedures to protect against such abuses, Dr Shaw says.

The three women were speakers at the 2nd World Congress on Prison Health Care held here recently. The conference, attended by about 700 delegates from 45 countries, was sponsored by Canada on behalf of the International Council of Prison Medical Services. The 1st World Congress was held in Dijon, France in 1978.

During the special session on health care needs of female offenders, Dr Shaw reported that 72% of women admitted to New York City jails in 1975 had at least one current medical problem. The most common was drug addiction, found in 23% of the women.

Subsequent studies of women inmates show a relatively high percentage are detained specifically for drug offences and drunkenness — crimes that carry high medical risks, Dr Shaw says.

She says medical staff must pay special attention to the needs of women prisoners.

"Because of their smaller numbers, lesser experience with the legal system, a focus on their children and family instead of themselves, and a general socialization toward accepting one's fate, women inmates have not been as able as men to stand up for their health rights."

Collective approach urged

(from page 1)

of several other provinces, even on a matter of only provincial concern such as the legal drinking age, it would be operating from a position of much greater strength than if it had the support of only a few people within the province."

At the national level, she said, commissions could approach bodies as a collective rather than as individual commissions addressing the needs of their own provinces.

The Newfoundland-Labrador commission was established a little more than a year ago amidst growing concern in the area about the potential for increased alcohol and drug problems in the wake of offshore oil and gas development (**The Journal**, Aug 81, Mar 83).

Ms Beck who is chief executive officer, joined later, after six years in adult education, with emphasis on community development and networking programs, at Memorial University in St John's.

On the potential social impact of offshore development, she said there is no doubt there will be development and an increase in alcohol and drug problems.

However, the wrangle between the province and the federal government over ownership of the resources from the sea has been so protracted, it has "almost made people complacent now in feeling there's nothing to be concerned about."

At the same time, the commission has been faced with getting established and dealing with "day-to-day crises such as the fact we have very, very minimal treatment facilities.

"The issues that are not smacking us in the face right now are kind of being left to one side. I'm not proud of the fact, but that's what is happening."

She said although there are various federal-provincial task forces on addictions with representatives of the provincial commissions, a group of chief executive officers would have the advantage of more immediate authority at the provincial level.

US military on alcohol binge as drug use eases

By Harvey McConnell

WASHINGTON — A significant increase in alcohol use and abuse in the United States military over the past two years has counterbalanced the crackdowns which brought a decline in illegal drug use.

This emerges from a worldwide survey of alcohol and non-medical drug use among 21,964 randomly selected members of the Army, Navy, Marine Corps, and Air Force questioned at 58 military installations.

The report for the department of Defense was carried out by Robert Bray and associates at Research Triangle Institute, North Carolina, and is similar to a 1980 survey. Another is planned for 1984.

The study found variations in drug and alcohol use patterns among the services, with the Air Force scoring lowest overall for adverse consequences.

Drinking among the military is almost universal: 77% of those questioned said they drank beer, 38% drank wine, and 53% hard liquor during the past 30 days. Overall, 84% drank their primary beverage during the past 30 days.

Frequent heavy drinking of beer is more common than of wine or spirits.

During the two-year period, those who drank 0.5 oz to 1.9 oz a day increased significantly to 30% from 26%, but those using five or more ounces a day decreased to 7% from 9%. "Overall, the trend is for an increase in the proportion of more moderate drinkers and a decrease in the proportion of heaviest drinkers," the report said.

Other findings: those who reported becoming drunk without planning to during the past 12 months rose to 38% from 20%; those who reported staying drunk more than one day at a time rose to 15% from 11%; those who experienced serious consequences of alcohol use rose to 14% from 11%; those who reported a loss of productivity during the past 12 months rose to 34% from 27%; and those who considered themselves alcohol dependent rose to 9% from 7%.

The report added: "Overall, military personnel in 1982 were significantly more likely to have become drunk, to have stayed drunk, or to have experienced one or more consequences of their drinking."

Those with alcohol problems tended to be male, less educated, younger, single, among the lower enlisted ranks, on active duty four years or less, stationed in the North Pacific or Western Europe, and at their current duty station less than three years.

The well-publicized drives against illegal drug use, and wide application of random urinalysis testing, has paid off: between 1980 and 1982, personnel reporting using any drug dropped to 19% from 27%.

The decline is due primarily to a sharp drop in use by the lower-paid enlisted men. The exception was a rise to 9% from 6% among the higher grades of enlisted men in the Army.

Marijuana use in the past 30 days dropped to 16% from 26%, and, again, the decrease was highest among the lower ranks of enlisted men. However, the decreases were more significant in the Navy, Marine Corps, and Air Force than the Army.

Other findings: a decline to 7% from 10% of those using more drugs than they planned; a decline to 9% from 17% among those reporting they had been high more than one day a week; a decline to 14% from 21% of those reporting diminished work performance due to drug use; and those indicating they were drug dependent dropped to 2% from 4%.

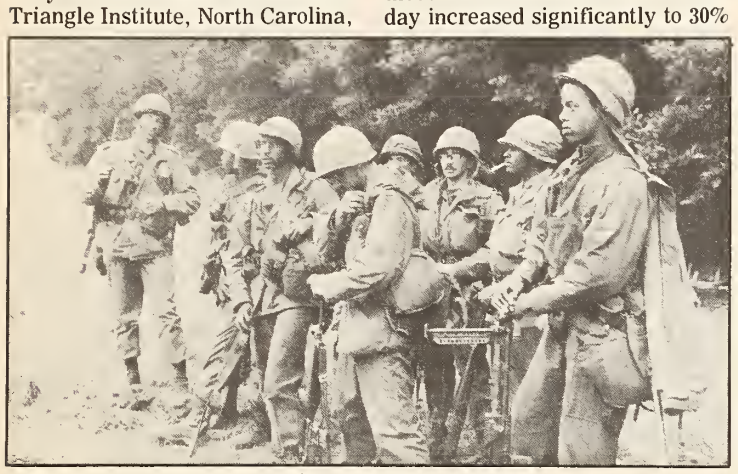
The report said the likelihood of drug use is highest among personnel with less than a high school education, aged 17 to 20 years, single, in lower pay grades, on active duty for four years or less, stationed in Western Europe, and at their current duty station for two years or less.

The researchers compared their findings with those among the US civilian population in the 1982 US National Institute on Drug Abuse (NIDA) survey of the general population (**The Journal**, May).

This showed that alcohol use in the past 30 days is higher in the military (85.6%) than in the comparable civilian population (75.7%). However, as the NIDA survey focused on drugs and did not contain details on the quantity and frequency of alcohol use, the meaning of a higher prevalence in the military is not clear.

Marijuana use in the military in the past 30 days (25.1%) is significantly lower than in the civilian population (34.7%).

Cocaine use in the military in the past 30 days is also significantly lower (4.6%) than in the civilian population (9.4%).



Enlisted men: young, low paid have highest use rates

DWI crackdown on US bases

WASHINGTON — United States Secretary of Defense Caspar Weinberger has ordered military base commanders to crack down on drunk driving.

He has ordered that a pass to drive on bases be denied for one year to any military personnel, their dependents, civil servants workers, and retired personnel who have base privileges, if they are convicted of drunk driving.

Commanding officers may, within 24 hours, suspend the base pass for anyone arrested for drunk driving. A year's revocation will apply as well to anyone suspected of driving under the influence but who has refused to take a blood-alcohol test.

NCA cutbacks are blamed on declining contributions

NEW YORK — A decrease in contributions to fight against alcoholism is a major reason the National Council on Alcoholism (NCA) has streamlined its operations.

National staff has been cut to 15 from 29, and the medical affairs and labor-management departments eliminated. Future focus, in line with a management consultancy report, will be on affiliate services, prevention and education, public information, and public policy.

The report said the organization faced large budget deficits in future unless corrective steps were taken. A major reason for the decline in the NCA's financial fortunes is a fall in contributions by individuals and firms, it said.

Board Chairman John Doyle, in a message to affiliates, said the board believes the changes will result "in a clearer public perception of what NCA is and what it does." Affiliates will benefit from fewer but stronger national programs.

Schools using breathtests to deter kids' drinking

LOUDON, VA — School officials here and in adjoining Fairfax county will now breath-test students from grades six to 12 whom they suspect have been drinking.

The two counties, both in the Washington, DC area, are believed to be the first in the United States to bring in the breath-test for elementary and high school students.

Concerned about the rising use of alcohol by teenagers, Loudon officials say the test will only be used after a student arouses reasonable suspicions he or she may be under the influence of alcohol. Those who show any trace of alcohol — or who refuse to take the test — face disciplinary action.

Officials in both counties say they are more concerned about preventing young people from drinking before they come to school than in catching them, and they hope the publicity will act as a deterrent.

Virginia law prohibits those under 19 from purchasing alcohol, and students cannot possess or consume alcohol on school grounds or attend school under the influence of alcohol.

Alcohol, pot play large role in sports accidents

By Harvey McConnell

WASHINGTON — Research into the part alcohol plays in many recreational accidents will be a top priority of Robert Niven, newly appointed director of the United States National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Dr Niven, MD, outlined what he sees as his role at the NIAAA, and the directions it will move, in an interview with **The Journal** following a speech to the annual conference here of the Alcohol and Drug Problems Association of North America (ADPA).

Canadian-born Dr Niven said that as a clinician at the Mayo Clinic in Minnesota prior to his appointment, he saw the victims of skiing, snowmobile, and boating accidents, and was impressed by how often drinking was involved.

He added: "During the past winter I saw a lot of kids who drank and smoked pot while they were out there skiing, and I am convinced it is a common phenomenon and plays a much bigger role in average health effects in kids than we realize.

"It seems drinking has become almost a normative part of downhill skiing, but not cross-country skiing. Most of the cases I saw didn't have serious adverse consequences, but they were common, and (occurred) at times of fairly heavy drinking."

Dr Niven, a skier and runner, said it has been 10 years since he came to the US and he does not know if a similar pattern exists among young skiers in Canada.

The attitude among young people that drinking while skiing was quite all right, and almost normal for many though not all, "is something that disturbs me."

As for snowmobiles ("I hate them, they are so noisy"), when patients are admitted "with bad facial lacerations, or concussion, or occasionally end up in the morgue because they were decapitated by barbed wire, I would make a lot of money betting you their accidents were alcohol-related. Almost all snowmobile accidents are."

Dr Niven said many beverage advertisements liken drinking to fun and recreation, and young people are affected by them.

Niven

He added: "The idea is to get some collaborative efforts going with other groups interested in accidental trauma and injury in the general sense — but in which I would also include violence — and to try to develop better data."

Although available data are sparse, "it became clear to me that whenever anybody has looked, there seems to be an association between alcohol and all kinds of trauma." The NIAAA now has increased funds to expand some of its epidemiological studies, and the US Centers for Disease Control in Atlanta, the department of Defense, and department of Transport are interested in improving on the data base.

The first step is to understand the problem and to get people to be more aware of the adverse effects of alcohol while engaged in recreational activities.

Dr Niven said a second major interest is children. To focus on just teenage alcohol abuse or the fetal alcohol syndrome "would miss the boat." There is a need to look at the broader issues, such as the effect on children who lose a parent to alcoholism, a drunk driver, or cancer of the lung from smoking.

"We need to know how much kids lose educationally in school. I have seen kids literally smoking marijuana on the way to school, and at noon hour they could hardly tell you what went on during the day. I think alcohol is having a major effect on education."

Dr Niven said he is more interested in prevention than treatment, and the NIAAA can no longer fund treatment programs.

He said: "I am not sure it is necessary at this point because in the private sector in this country, and that may not be true in Canada from my perception of what is happening there, treatment is well accepted and there is not the problem in having access to treatment there was 10 or 12 years ago."

The agency, for now at least, will not be involved in clinical training, but will try to get research findings and policy issues to the field.

As for how he sees his role as NIAAA director, Dr Niven declared: "I think having a clinician as a director is a benefit because I was viewed as a clinician, and a large part of a clinician's job is in bridging that gap between knowledge and practice.

"Knowledge is never complete, and practice is never perfect, and the good clinician tries to blend the two for the benefit of the patient.

"The state of the art is that we have got a lot of knowledge and a clinician can, I think, help pose some research issues and some directions that some of the research might take. I emphasize only in part, because I am a great believer in having high-quality research open on any aspect of alcohol use.

"But if we can direct some of the research, we might end up with some solutions to some of the problems in the field."

Dr Niven said he believes in the next decade some significant advances will be made which will have major clinical relevance. For example, some of the basic biomedical research on the metabolism of alcohol may produce useful pharmacological interventions.

NEWS

Treatment workers facing rough times as US field shifts financial gears

By Anne MacLennan

RACINE, WISC — Treatment professionals in the addictions field are going to be "thoroughly stressed" for the next two or three years, says a veteran of 26 years in senior levels of the United States public health and drug abuse field.

But, those who have not already succumbed to funding pressures will probably survive, says Karst J. Bestemann, a chief drug programs officer for the US National Institute of Mental Health from 1967 to 1973 and deputy director of the US National Institute on Drug Abuse from 1973 to 1980.

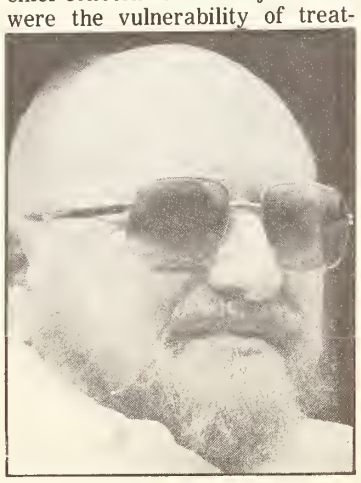
"Life is going to be very uncomfortable over the next couple of years — especially for treatment people — because of dollar concerns and constraints," he told **The Journal**.

"Treatment is not going to get cheaper, and the dollar supply is not going to get any greater."

Services "are not going to grow and some may have to shrink a little bit. But, they're going to be here. I think the people who are not going to survive have already left."

Mr Bestemann, now regional health administrator for the US Public Health Service for New York, New Jersey, Puerto Rico, and the Virgin Islands, was a participant in a think-tank meeting here recently of about 40 US leaders in the field — the 1st National Invitational Policy Forum on Alcohol and Other Drug Problems. Represented were prevention and treatment programs, private and public sectors, local, state, and federal governments and associations, and the alcohol beverage industry (**The Journal**, Sept).

Lack of federal leadership was a chief concern. Other major issues were the vulnerability of treatment services to funding cutbacks, and to the growing emphasis on prevention.



Bestemann: pattern is healthy

Mr Bestemann told **The Journal**: "Obviously, when there is concern with cost, prevention becomes attractive because you can do more with less. But it's not a sudden swing. We discussed it as an issue in 1972, and it's still gaining momentum.

"We still lack some of that nice, neat evaluative data. But for a decade people have been doing things and have more than anecdotal information in support.

"Companion to that, the whole health area has turned to prevention. The country has turned to wellness, fitness, nutrition. We're in a nurturing environment right now.

"It's not a rush to prevention. It's simply taking advantage of the opportunity that came rather slowly. I think everyone who is in the field and survives will probably be able to say that with more clarity four or five years from now."

Mr Bestemann summed up the tone of the forum as "fragmented but not contentious."

"I have been at meetings similar to this over the years where we'd agree in principle on an issue, and an argument would take place over which organization should take credit for leading the field in this direction.

"The healthy part of this conference is in the diverse representation, the fact there is no insistence by any one organization represented that it owns the leadership.

"Whether this means some sort of new coalition is going to emerge, or whether it's a maturity of associations saying we're going to work together and not just fight, we're going to have to go down the road a little while to see."

He said frustrations about lack of leadership are a product of being in a "transitional" stage. The field "is just now reacting to taking responsibility for its own future.

"Really aggressive federal leadership" in the late 1960s and early 1970s made people in the field comfortable with looking to the federal government for specific leadership.

"There used to be discussions of how services would be funded before the decision was made to fund them. Now, with block grants to states, and the emergence of the reimbursement system (by which facilities are reimbursed on the basis of service provided) we're back to fitting the field into the sytem."

Mr Bestemann said despite the resulting fears and fragmentation, "philosophically and programmatically, the change in the pattern is really healthy."

The forum was sponsored by The A-Center, Racine, the National Association of State Alcohol and Drug Abuse Directors, the Alcohol and Drug Problems Association of North America, the National Federation of Parents for Drug-Free Youth, and The Johnson (wax) Foundation in Racine.

Another forum is being planned for next year to "further seek consensus about needed policy objectives and strategies for achieving them." Participants also recommended a North American congress be held in 1985, with representation from Canada and Mexico as well as the US, to highlight policy objectives developed in the forums and to examine additional policy issues of concern to the field or public.

RESEARCH UPDATE

Near beer passes taste test

A study of young social drinkers has shown that by taste alone it is not possible to tell the difference between beer and near beer which contains no alcohol. University of Minnesota researchers W. Miles Cox and Eric Klinger asked 19 current beer drinkers to judge the alcohol content of 1oz samples of regular beer with 3.2% alcohol, light beer with 3.2% alcohol, near beer with less than 0.5% alcohol, and near beer with enough added alcohol to bring the content to 3.2%. It was found that the tasters could usually distinguish regular beer from near beer when these were tested in sequence and tasters were informed of the varieties of beer they might be tasting. However, the researchers said the distinction is not attributable to the alcohol content since "there was no ability to distinguish near beer with ethanol from that without." An additional test using an informal party setting found that "during more than two hours of partying . . . none of the four uninformed guests spontaneously detected the near beer." The researchers concluded near beer could be useful as a placebo in test situations.

Journal of Studies on Alcohol, May, 1983, v.44:494-498

Anesthetists most vulnerable medics?

Drug abuse among anesthesia residents and instructors may be more common than generally believed and perhaps more common than in other areas of medicine. This was the finding of a survey of United States anesthetist-training programs aimed at gathering information on incidents of drug abuse between 1970 and 1980. It was conducted by researchers at the department of anesthesiology, University of California, San Diego Medical Center. Of the program directors responding, 74% identified at least one suspected episode of abuse, with the overall incidence of confirmed abuse being estimated at 1.1%. Abuse was higher among instructors than students, and meperidine and fentanyl, both synthetic narcotics, were the most frequently abused drugs. Fentanyl is not well known outside the field, and the researchers said its prevalence is ominous because it is largely undetectable in urine screening and has a high potency. The study concluded the higher incidence of drug abuse in anesthesiology may be partly due "to the ubiquitous availability of remarkably potent drugs."

Journal of the American Medical Association, Aug 19, 1983, v.250:922-925

Heart patients who quit smoking do better

Stopping smoking has been shown to have long-term benefits for patients with coronary heart disease. A study in St Vincent's Hospital and University College, Dublin, followed up 498 men aged less than 60 years who had survived a first episode of unstable angina or myocardial infarction by two years. Through actuarial life table methods these men were followed for a further 13 years; mortality among those who continued to smoke was significantly higher at 82.1% than in those who stopped smoking, who had a mortality rate of 36.9%. The effect of continued smoking was most pronounced in those with unstable angina, and it increased the sudden death rate to a greater degree in those with less severe initial heart attacks. The researchers concluded there is no doubt "that stopping cigarette smoking is the most effective single action in the management of patients with coronary heart disease."

British Medical Journal, July 30, 1983, v.287:324-326

Soldier flashbacks

Examination of United States soldiers discharged in one year as unfit for service has shown that flashbacks associated with the heavy use of at least one drug are a common but complex phenomena. Of 280 soldiers seen at one army clinic and scheduled for discharge, 207 reported heavy multi-drug use, and of these 71% reported having flashbacks, report California researchers Joel Yager, MD, Evelyn Crumpton, PhD, and Ralph Rubenstein, MD. While most of the flashbacks were reported to be of a simple visual nature, complex subjective experiences and persistent difficulties in concentration were also noted. The study found the likelihood of reported flashbacks being severe was strongest in relation to hallucinogens; prevalence and severity increased with drug use, especially with hallucinogens and marijuana. The researchers said the findings "may not be representative of the general prevalence of flashbacks in multi-drug users," that several factors may contribute to the occurrence of flashbacks, and that the phenomenon is "very complicated."

American Journal of Psychiatry, July, 1983, v.140:857-861

Family members may have problems

EAPs miss alcoholics' adult kids

By Harvey McConnell

PHILADELPHIA — Most employee assistance programs (EAPs) are geared specifically to helping the alcoholic and are ignoring other family members.

Yet it is the adult children of alcoholics who often suffer from a number of problems in both their personal lives and at work, believes Peggy Carey, the director of EAPs for New England Bell Telephone Company.

A lot of research has been devoted to the effects of an alcoholic parent on young children, but little has been studied of the effects on adult children, she told the National Conference on Alcoholism and the Family here.

Ms Carey: "When seen in the work force, the typical adult child of an alcoholic has difficulty in personal relationships, problems with the boss and with authority figures, and a general feeling of depression in both personal and work life."

This can lead to deteriorating work performance, absenteeism, tardiness, moodiness, poor attitude, and high utilization of sick leave.

"Thus the adult children of an alcoholic family member are going to be a great cost to corporations, and it makes economic sense for companies to pay attention to this problem," she added.

Ms Carey said many mental health clinics can mistreat clients because counsellors don't pick up on a drinking history in the family "and nobody ever deals specifically with the problem."

Ms Carey, who comes from an alcoholic family, said that when she went to work for her company five years ago in their social services program she checked on clients after one year. "What we found was that 59% of the people coming through our EAP with performance problems were family members of alcoholics, or wives and mothers of alcoholics."

People from alcoholics' families may be just as sick as the alcoholic, but because most programs are geared specifically to alcoholics and alcoholism, "family members have been virtually ignored."

Ms Carey and two counsellor colleagues developed their own model of treatment, "even though we were feeling in the dark," and acted both as counsellors and group members.

They had to be confrontive "because many of these people don't see alcohol as a major factor in what is happening to them today as grown up children of alcoholics."

Ms Carey said lectures on stress, which are popular, contain a component on alcoholics and alcoholism and how it affects family members. This has led to a large number of self-referrals. "We just reach out and pull people in."

Moonlighting referee - MD scorns tobacco promos

AUCKLAND — What does an anti-smoking campaigner do when he is also a rugby football referee and his sport is sponsored by tobacco companies?

This is the dilemma facing Australian chest physician David Lindsay, a specialist in thoracic medicine and director of the respiratory laboratory at the Royal Prince Alfred Hospital in Sydney.

An authority on asthma, he treats patients who have smoking-related diseases but is also involved officially in a tobacco-sponsored sport.

"I have personally had problems because as a referee in Sydney I have to award points for a players' medal called the Rothmans Medal," he said during a visit to New Zealand for National Asthma Awareness Week.

"This is rather embarrassing for a chest physician. Allowing for the fact this is a product we know is noxious, and there is so much scientific data on cigarette smoking, it is ridiculous that the community is in a sense supportive of the industry."

Dr Lindsay refused to go to the dinner where the Rothmans Medal was presented last year. And he hopes to get the referees' association to refuse to award points for the medal in future.

There's no easy solution, officials admit

Glue sniffing problem is escalating in Britain

By Alan Massam

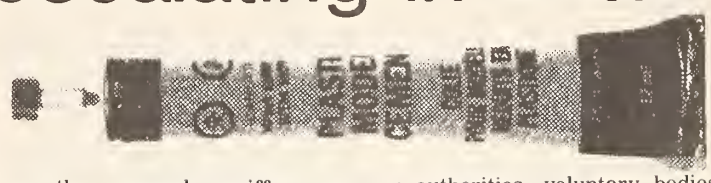
LONDON — The British Medical Association is to investigate new approaches to the escalating problem of glue sniffing here. The decision was made at the association's annual meeting in Dundee when delegates revealed a degree of medical concern which hasn't previously been apparent.

Most agreed dealing with the problem effectively would not be easy.

The debate did, however, arouse the Department of Health and Social Security (DHSS). John Patten, parliamentary secretary for health, issued a statement after the Dundee meeting clearly intending to discount any suggestion that the DHSS was not appraised of the situation. "There can be no doubt that this is a potentially dangerous pursuit. There is clear evidence that some of these substances do permanent damage.

"I would say to any teenagers tempted to try it out — don't do it. It is not worth it. To those who are already sniffing glue I would say, if you find you can't stop, ask for help — go to your parents, teachers, or youth leaders.

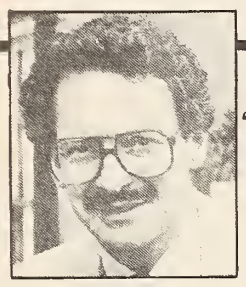
"Parents and friends have a key role to keep an eye open for young people in trouble to try to make



sure the young glue sniffers are helped before they get into serious difficulties.

"Solvent abuse is at present being handled through education and counselling and by local initiatives in many areas where local statutory authorities, voluntary bodies, and retailers are cooperating with parents and teachers in tackling the problem at ground level.

"Experience shows that such joint efforts can be effective if well informed and well organized."



GILBERT

'. . . chronic solvent abuse may be the most hazardous form of drug use known in industrialized societies. . .'

Solvent abuse

By Richard Gilbert

My neighbor reminded me about the problem after he had been in a local hardware store at 8 o'clock one morning in July — a store, incidentally, that is a stone's throw from the main building of the Addiction Research Foundation (ARF) in Toronto. Two 15 or 16 year olds, a male and a female, were buying lacquer thinner. They behaved oddly, spending an unusual amount of time rummaging around pockets and bags for enough nickels and dimes to pay for the fluid. "They're starting early today," commented the store owner.

My neighbor was horrified and sought more information. The owner explained that this particular pair came in two or three times a day — when they had accumulated enough change from a bout of panhandling. He had other customers of this kind too.

"Why do you sell the stuff when you know what it's being used for?" asked my neighbor. The owner replied that he couldn't, under the law, refuse to sell solvents and that if he didn't sell them buyers would get them from other stores anyway. He said he called the police when customers started sniffing the stuff in his store. The police would take the kids away but they would be back in the store within a few hours, he said.

I had thought solvent abuse had virtually died out in Toronto. Certainly, I had not encountered it since an incident a few years ago in the changing room at a local swimming pool. A couple of spindly boys in their middle teens were puzzling my then seven-year-old son with their desperate inhalations from a paper bag. It was difficult to explain what was happening.

On the decline

The staff inspector in charge of the Youth Bureau of the Metropolitan Toronto Police supported my impression that glue sniffing and other kinds of solvent abuse had been on the decline for some years. There were still occasional incidents, notably on transit vehicles and in subway stations, but it was no longer the kind of issue it used to be. There are no police statistics on solvent abuse because there are no laws concerning the distribution and use of these substances.

I spoke with Keith White, former director of Project Solvabuse in Hamilton, Ont (**The Journal**, May, 1978), who follows the sniffing scene closely. He pointed out that the frequency of incidents of solvent abuse appears to be cyclical, and does seem now to be at a low point in Toronto. The last peak, he said, was in 1978. In one week of that year he found more than 2,000 glue tubes in two Hamilton parks.

I spoke with the hardware store owner whose casual acceptance of what was going on had horrified my neighbor. The store owner also mentioned how use seems to go up and down. He had had a lot of demand from obvious abusers for lacquer thinner and contact cement cleaner in the spring and early summer, but during August they seemed to have stayed away. He offered a further reason for selling solvents to abusers. Refusal would bring a brick through his window. At another local hardware store, the manager explained he had always taken a very hard line on the sale of solvents to likely abusers. This store hadn't been bothered for some years.

ARF psychologist Adrian Wilkinson is a member of an industry-government task force on solvent abuse. He said that abuse "is of such low frequency that it is difficult to determine whether it is on the decline or not."

While there is some evidence of a decline in use in the regular enquiries conducted by the ARF among school children, perhaps the best guess as to prevalence is that about 10% of kids inhale solvents for "recreational" purposes in any one year. By Dr Wilkinson's reckoning, about one in 1,000 of those 10% may become chronic users.

The Institute for the Study of Drug Dependence (ISDD) in Britain has argued that while chronic use is harmful, recreational use is unlikely to be — except for those occasional episodes of acute intoxication. Thus the ISDD, suggesting that since it is almost impossible to eliminate "recreational" or experimental use, has produced a pamphlet for youth workers and health educators setting out some simple advice that might be given to children on what to sniff, how to sniff, and how much to sniff, if they insist on doing so (**The Journal**, June, 1981). There is more alarm in Britain about solvent abuse than in North America. Much of the research on the problem is being done there.

Perhaps the most significant piece of research on the subject, however, was done here at the ARF. Four researchers, including Dr Wilkinson and led by Dr Luis Fornazzari, engaged in extensive study of the brains of chronic solvent abusers. They found severe deterioration in most of those tested. (This work was first reported in **The Journal** in May, 1982. The formal report appeared in *Acta Neurologica Scandinavica* earlier this year.)

Dr Fornazzari and colleagues gave standard psychological and neurophysiological tests to 24 subjects during a two-week hospital stay. They also administered computerized tomographic brain scans to and took electroencephalographic recordings from the brains of many of the subjects. These subjects (21 male, 3 female) had all reported daily use of solvents for at least a year. Their mean reported length of use was 6.3 years. The mean reported amount of use was equivalent to 425 mg of toluene per day (typically in the form of one 10-ounce can of contact cement cleaner). The average age of the subjects was 23 years.

Profound impairment

The principal findings, according to the authors, were that "long-term chronic inhalation of products containing toluene is associated, in some users, with a behavioral syndrome showing profound impairment of motor control and associated impairment of some intellectual and memory capacity. The behavioral deficits are accompanied by marked brain atrophy, particularly in the cerebellum, but also noted in the cerebral ventricles and cortical sulci."

The authors also reported that "there was not a clear relationship between chronicity and level of current abuse and the behavioral or neuroradiological scores." This "surprising aspect of the results" occurred, they said, because a few of the unimpaired subjects reported themselves as chronic heavy users.

The particular significance of this study is that it is by far the clearest demonstration to date that chronic solvent abuse can be extremely hazardous. Indeed, the extent of damage found in the majority of the tested subjects indicates that chronic solvent abuse may be the most hazardous form of drug use known in industrialized societies. Other work, mostly consisting of individual case studies, has implicated solvent abuse in bilateral optic neuropathy to the point of blindness, hearing loss, epilepsy, and kidney and liver damage.

Dr Wilkinson observed that solvent abuse is a most interesting topic from a public health perspective. It embodies most of the familiar drug abuse issues, and yet solvents may be the only compounds used for their pharmacological effects that are sold primarily for other reasons. He stressed the importance of distinguishing between occasional and chronic use, noting that chronic use causing irreversible damage appears to be extremely rare. Prevention of damage involves most of the considerations that arise with other drugs: what, for example, is the better approach, to reduce the supply, or to penalize the abuser?

One method of reducing supply that has been suggested is to contaminate the product so that it becomes unpalatable. One problem here is that the contaminants may be even more harmful than the standard solvents, thus increasing the risk of damage among those who sniff the substances regardless. A second is that the general public would be exposed to the toxin during regular use of the solvent.

Another method that has been tried is municipal legislation. Winnipeg City Council, prodded by a group of concerned citizens, made it an offence in 1969 for retail outlets to display intoxicating substances such as model airplane glue in containers of less than one litre in self-serve displays. The by-law was quashed by the Manitoba Court of Appeal in February, 1982, overturning a lower court that had ruled against an objection to the by-law by Zellers, Inc. Two of the Appeal Court judges ruled that the action by the City of Winnipeg infringed upon federal jurisdiction. (**The Journal**, April, 1982).

The response of the federal government to the problem has been to establish the task force that Dr Wilkinson belongs to. It does its work under the auspices of the Hazardous Products Branch of the Ministry of Consumer and Corporate Affairs. The task force was welcomed by solvent manufacturers. They preferred federal action, if anything, to the patchwork of municipal regulations that seemed possible at the time the task force was established. The emphasis has been on devising voluntary procedures that can be implemented by manufacturers, although the possibility of legal action is not being overlooked.

The voluntary procedures have the following components:

1. Frequent stories in trade magazines. These apparently have appeared and may have had a powerful effect on distributors and retailers.
2. Identifying abused substances. This will be done by the ARF in Ontario, relying on current sources of information (including street talk) rather than special investigation.
3. Including warning flyers in wholesale cartons of substances that are reported as being abused. This part of the program does not yet seem to be under way, although Dr Wilkinson noted that LePages' Ltd, the largest manufacturer of these products in Canada, may have been enclosing such flyers for years.

Complaints

LePages', whose senior executive sits on the task force, was in the news last year as having eliminated toluene from its contact cement cleaner (**The Journal**, May, 1982). A company spokesman reported a deluge of complaints at the time, most of them, he thought, from solvent abusers. I checked the label of the cement cleaner on the shelves of a local hardware store (the one not frequented by abusers) and found that toluene was a constituent. The can was part of a consignment delivered to the store in August, 1983.

Studies of abusers have usually found them to be among the saddest of society's victims, mostly emotionally deprived adolescent boys or young men. Lacquer thinner provides the cheapest of escapes, and what seems to be a sure route to suicide if use is sustained. I doubt, however, whether legislation is the best means of preventing these deaths and the occasional accidents that occur during recreational sniffing. Products containing solvents have become too indispensable in homes, crafts, and trades for there to be reasonable enforcement of restrictions upon sale.

Usually people in the drug abuse field do not think much of actions by manufacturers of abused products to curb abuse. In this case at least, the manufacturers are probably giving the best advice as to how abuse might be curtailed. For them, the pharmacological effects are an inconvenient by-product rather than the reason for the products' popularity.

If the manufacturers follow their own advice, solvent abuse may become a thing of the past. Would-be glue sniffers may then resort to something else. At least until recently, gasoline sniffing has been a common problem among young people in certain northern Indian communities in Canada. The worst consequence here is lead poisoning. An epidemic of gasoline sniffing would bring spectacular hazards to a large city.

NEWS

Lawyers want drunk drivers suspended longer

QUEBEC CITY — Bumper stickers and longer licence suspensions could be more effective in inhibiting drunk drivers than stiffer prison sentences, a Regina lawyer told the annual meeting here of the Canadian Bar Association (CBA).

Morris Shumiatcher was proposing an amendment to a CBA Council resolution on drunk driving. He said extended jail terms would have some impact, "but what really troubles people is the loss of the driving privilege. That's really where the rub lies."

Earlier in the week-long meeting, the Council — the CBA's main decision-making body — had rejected a resolution calling for lifetime licence suspension and a minimum penitentiary term of two years for dangerous driving or criminal negligence causing death while impaired. The lawyers were concerned that an impaired driver, involved in an accident while driving prudently, could be unjustly tried and convicted.

A compromise resolution, hastily drafted by Winnipeg lawyer David Matas, suggested "more severe sentences for these offences ought to be imposed, reflecting the seriousness of the crimes and the harm to society."

In arguing for his amendment to the compromise resolution, Mr Shumiatcher said it isn't enough to focus solely on sentencing as a deterrent.

"This resolution proceeds upon the premise that we're all expected to accept, that the heavier the jail sentence, the more likely the imprisonment, the greater the adherence to the law will be," he said.

"Far more effective than sending a person to prisons that are not able to accept him . . . is the suspension of driving privileges."

In the United Kingdom, Mr Shumiatcher said, drunk drivers lose their licence for life if they're involved in an accident causing injury or death. In some other jurisdictions, drivers are required to place a bumper sticker on their vehicle declaring that they drink.

He said that in addition to keeping potentially hazardous drivers off the road, suspensions are "a visible sign to his friends and family and associates that he's a drunken driver. That's an inhibitor."

The eventual resolution, adopted by the CBA Council with only one dissenting vote, called for stiffer sentencing and longer suspensions for drivers under the influence of alcohol or drugs.

MDs want emphasis on roadside checks

By Betty Lou Lee

TORONTO — A major program of roadside checks by police should be introduced in Ontario to combat drinking and driving, says the Ontario Medical Association (OMA).

The OMA has called for "frequent, highly-visible, and widely publicized" checks throughout the province, in a vote at its annual meeting here.

The OMA will also become more involved in public education programs to stress the dangers associated with impaired driving.

Its committee on accidental injuries has given priority to strategies to reduce traffic injuries related to drinking, and considered three categories: those that decrease drinking, those that decrease drinking and driving, and those that decrease the likelihood of death or injury in an accident.

In the first category, the committee reports raising the drinking age "has little chance of adoption by government" and raising the price of alcohol "is already occurring."

Economic incentives to reduce drinking-driving might include higher taxes on parking areas of drinking places, and low taxes for pedestrian taverns; "bounties" for taxis that take home people who drove to taverns; and encouragement of private industry to subsidize public transportation at high risk times of the year.

The committee considered three elements of arrest and punishment strategies. The risk of being caught is about one in 1,000, and it would cost too much to raise that risk significantly. A more effective deterrent, the committee said, occurs when such drivers believe they will be caught.

"Thus, if spot checks are carried out by police in the places and at the times that drinking and driving is most likely to occur, and if these spot checks are highly visible and highly publicized, reductions in drinking-driving will occur." But since the effect lasts only a few months, there should be periodic, brief "blitzes" of checks, again with a lot of publicity, the committee said.

Increasing the severity of punishment increases the likelihood of acquittal and, therefore, "will probably be ineffective or even harmful if carried out in isolation," the committee concluded.

The OMA also endorsed a Canadian Medical Association position that a driver should consent to a blood alcohol test on demand as a condition of getting an initial driver's licence or a renewal, and that medical personnel involved should be protected from legal liability.

Ontario Task Force recommendation

DWI unit to link gov't-community

By Gary Lamphier

TORONTO — Ontario Premier William Davis' Interministry Task Force on Drinking and Driving, formed in Sept, 1982, has begun its public campaign to rid the province's roads of drunk drivers.

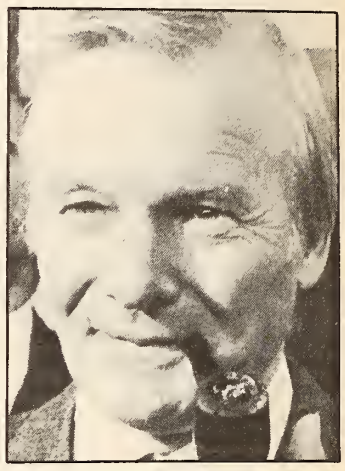
In an announcement at Queen's Park Sept 1, Ontario Attorney-General Roy McMurtry, chairman of the task force, said the government has decided to adopt one of the key recommendations contained in a 112-page discussion paper released by the task force: the establishment of a permanent office to coordinate efforts aimed at eliminating drunk driving.

Mr McMurtry named James Erskine, 61, former commissioner of the Ontario Provincial Police, to head the new office. It will operate within the Attorney-General's ministry, and Mr Erskine will report directly to Mr McMurtry.

The new unit, said Mr McMurtry, has three main tasks: to provide a two-way link between government and community groups; to coordinate various government, community, and private sector efforts to combat drinking and driving; and to stimulate grass-roots campaigns to fight drinking and driving.

Mr McMurtry declined to commit himself to other task force recommendations, including proposals to introduce photo licences, mandatory blood samples where appropriate, and increased data collection. But he did announce plans for a seminar to monitor existing efforts to combat the problem, "and to foster interest among municipal officials and organizations in undertaking a program in their community."

McMurtry: nothing lavish



Davis: personally appalled

Mr McMurtry said the government also plans to "participate" in various grass-roots projects to assess their success.

"We do not plan any lavish, big-buck, glossy approach," he said. "We will be trying to stimulate community initiatives, to rely on community expertise and commitment. We will be challenging community and municipal leaders to come up with effective campaigns for their own areas. Most important of all, we will be counting on the evolution of public attitudes."

Premier Davis, in an accompanying statement, said: "The grim fact is that every day in this province alcohol is involved in the deaths of two people and 81 motor vehicle collisions. At least half of all drivers killed each year have been drinking. Traffic accidents are the fourth leading cause of death in Canada and the number one killer of people under age 30. In 1981, 45,910 drivers were convicted of drinking-and-driving offences."

He said as a parent, and grandparent, he is "personally appalled" by these figures.

Spokesmen for PRIDE (People to Reduce Impaired Driving Everywhere), an organization that lobbied for the establishment of the task force, congratulated the government for taking action. But John Bates, PRIDE president, argued that stiffer court sentences are still needed.

"Nobody in the country has ever received the maximum sentence for a first offence, ever," he told a *Toronto Star* reporter. "Taking a trout out of season brings a heavier penalty than drunk driving."

It's time for war on tobacco industry: Daube

By Mark Kearney

WINNIPEG — Health officials have to stop being pleasant and start a vigorous attack on the "very tough, cynical" tobacco industry for creating a public health catastrophe, says a British anti-smoking activist.

"We do want them to feel damned uncomfortable," says Michael Daube, senior lecturer in the department of community medicine at the University of Edinburgh in Scotland. "We want to make it privately and publicly embarrassing for them to be in the industry."

Mr Daube says the time has come for this strong stance because years of trying to work things out with the tobacco industry have led nowhere.

"You can't get anywhere by negotiation," he told **The Journal**. "You can't get anywhere by treating them as people who can be persuaded."

Daube: unfair, unsporting

Health officials should focus on individuals responsible for cigarettes in addition to criticizing the industry as a whole. Letter-writing campaigns and phone calls to the individuals and shareholders pointing out the problems created by the industry will be more effective than past actions, he says.

Mr Daube told the 5th World Conference on Smoking and Health here that health advocates must use the media and politicians more often to publicize their case.

The public has to be made more aware of the amount of disease and the social problems created by these "merchants of death." If attacking individuals in the industry is the most effective course, it should be followed, Mr Daube says.

"It's unfair, it's unsporting, and it's unconventional . . . but they're in a business that's unsporting. How (well-mannered) can you be with an industry that's responsible for one million deaths a year?"

Such tactics may lead to criticism "but we're not playing a game. It's a public health catastrophe." However, he sees public opinion shifting more toward his cause and, as his stance becomes increasingly popular, more politicians are likely to support him.

Kjell Bjartveit, MD, an adviser to the World Health Organization (WHO), told conference delegates the goal of "Health for all by the year 2000" won't be achieved without mobilizing politicians throughout the world. That means stronger lobbying by health officials at all levels of government.

"Without political involvement we'll never reach that goal. Therefore, let us act, and let us act now," Dr Bjartveit says.

There are more politicians now who are willing to join this battle against the industry, he told **The Journal**, because they realize the negative effect smoking has on health.

As they become more aware of the problems, they may be more receptive to proposals on banning advertising of tobacco products, he says. The industry spends $1 billion on advertising and then says it doesn't have any effect on consumption.

Dr Bjartveit dismisses the argument that the economy could be disrupted if the tobacco industry were harmed by such a ban. The tobacco industry has enough other products and corporations that could compensate for any losses if cigarettes don't sell as well as they have in the past.

"Speed up that (diversification) process. That's what I say to them."

Our mistake

An article on Maison Jean Lapointe, Centre benefits from namesake's renown (**The Journal**, Sept), said: "Following discharge, counsellors pay personal visits . . ." In fact, ex-residents visit the centre for two months following discharge. **The Journal** regrets the error.

Call for abstracts

NEW YORK — Deadline is November 1 for abstracts of papers for the National Council on Alcoholism's (NCA) 40th anniversary forum in Detroit, April 12-15, 1984. The theme of the meeting will be Celebrating Prevention. Papers on prevention, education, public information, public advocacy, fundraising, counselling and therapy, college programs, and nursing are requested to be sent to: Forum Coordinator, National Council on Alcoholism, 733 Third Ave, New York, NY 10017.

NEWS FEATURE

'Conclusions of a decade ago totally unacceptable today'

Officials justify cannabis literature update order

By Harvey McConnell

WASHINGTON — Attempts by the United States National Institute on Drug Abuse (NIDA) to update its publications with the latest biomedical and epidemiological research on drugs, particularly marijuana, has enmeshed the agency in an emotional and political crossfire.

Director William Pollin, MD, acting on scientific grounds, in a letter has asked state agencies and state libraries to withdraw some earlier NIDA publications and substitute those containing current research data.

His action has brought a cry of "book burning" from some sections of the substance abuse field.

At the same time, however, NIDA officials are still being bombarded by some parents and parent groups who are lashing out at anyone — agency or individual scientist — they consider currently or historically responsible for their children's drug use.

Dr Pollin tackled critics of the updating policy following an address to the annual conference of the Alcohol and Drug Problems Association of North America here. He told **The Journal** the letter was solely his decision and he explained: "Marijuana is not the big issue. The issue is that we have a situation in this country now that didn't exist 25 years ago, when high school kids may have gotten drunk on a six pack, but they didn't use other drugs.

"Now drug use by high school kids is par for the course, and that's a genie we are never going to get back into the bottle.

"It didn't have to happen, and part of the reason it happened is that there was a series of statements and policy positions, and policy attitudes, communicated by the prestige media, by some of the groups in the country which most of us felt usually were most reliable, such as the Consumers Union report 10 or 12 years ago which said, in effect, 'look, drug use by our young people isn't that big a deal, society's overreacting.'

"I think that was a very, very unfortunate point of view, and I think it is a point of view which now needs to be retrospectively held up and criticized, because if you don't really see where you went wrong, you can't prevent similar mistakes in the future.

"The tendency to accept drug use by our young people as something that was no big deal was a tragic mistake, and it needs to be rectified.

"Epidemiology has moved further in this field than probably any other field, and you know who is using what, and you know a lot about the consequences.

"And we know that the Shafer (Commission's) report and the title *Marijuana, A Signal of Misunderstanding* was a perfect example of ignoring the serious problem that drug use by our young people presented in our society, and treating it instead as a social issue.

"The overall patterns of increased drug use by American teenagers has been a national tragedy," Dr Pollin said.

Many conclusions and recommendations made a decade ago "most of us would find totally unacceptable today." Until the late 1970s, for example, evidence of behavior and health effects with regard to the use of drugs was primarily derived from studies in healthy adults and not in young teenagers.

Dr Pollin said the NIDA became concerned that in a significant number of libraries, treatment programs, and other repositories of information, the only publications available were those which expressed the point of view of the early 1970s.

"It is the furthest thought from my mind, in any sense, to indicate some current American version of a 'book-burning' procedure. There are all kinds of reasons why the materials that were developed should be retained for historical reasons."

Dr Pollin's position is supported by Lee Dogoloff, director of the White House Drug Abuse Policy Office under president Jimmy Carter, and Carlton Turner, PhD, now director of the office under President Ronald Reagan.

Mr Dogoloff is now executive director of the American Council on Drug Education, which holds conferences and publishes monographs on current drug use. President is Robert DuPont, MD, who, while still director of the NIDA, was one of the first to warn that scientists may be giving "mixed messages" to the general public (**The Journal**, Aug, 1977).

Mr Dogoloff told **The Journal**: "Would you suggest to a student of say neurosurgery, space exploration, computer sciences — you name the field of endeavor — that a person who is trying to understand the current state of the art read something that was written five years ago, three years ago, 10 years ago, 12 years ago? That's the question, and it is not 'book burning' if you are trying to update information.

"Twelve years ago when *Licit and Illicit Drugs* was published by the Consumers Union, it was the current, up-to-date, best information available. It is still probably in circulation in most libraries; everywhere you go you can find it.

"The problem is that 12 years later it is not current, and anyone who picks that up doesn't have the information to be discerning enough to say this is right and this is wrong. It has been overtaken. For example, 12 years ago we knew nothing about endorphins.

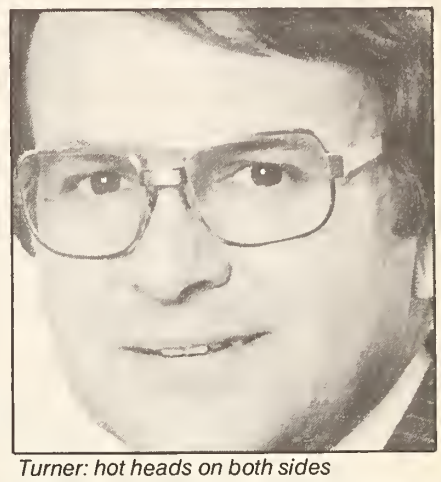
"There is so much you learn. If not, why would you justify spending all that money on research? That is the critical issue.

"Much of what we know is fairly recent, and it is clear in virtually every area that the younger the organism, the greater the damage from drug use, and we have children using drugs at a younger and younger age. The increased potency of marijuana, for example, in effect almost makes it a new drug we are dealing with.

"I think it takes a lot of courage for Bill (Dr Pollin) to say that, and he is absolutely right.

"I don't care if the books are pulled off. I would be just as happy if they have a stamp printed which says something to the effect: 'This information represented the state of the art in the year it was published, but since then a great deal has been learned, and it is suggested you seek more current writing on the subject.'

Pollin: where we went wrong



Turner: hot heads on both sides

Dogoloff: almost a new drug

"When things have been overtaken by events you do this sort of thing for the other areas of science, and why would you not do it here? In science, as in most other areas, you are building on information, although you don't have the confusion that is built into the drug, particularly marijuana, issue.

"You don't go from Reefer Madness to the Shafer Commission — taking virtually diametrically opposite viewpoints based upon almost the exact amount of scientific evidence available at the time, which was virtually none — and then try to square that away as the real evidence begins to emerge."

Mr Dogoloff is certain "within the next two or three years we are going to have to update some of our own publications because more scientific evidence has accrued."

As for the pressures being put on the NIDA and some scientists, Mr Dogoloff adds: "I think we have to be very mindful of the relationship and balance between external factors that can certainly influence our children, and not confuse them with the basic responsibility for their healthy growth and development, and for imparting values to our children, which still belongs to parents.

"We shouldn't, as parents, delude ourselves into putting that responsibility on someone else."

Dr Turner told **The Journal**: "I wholly support whatever Bill (Dr Pollin) is doing. While, of course, you are going to have a few hot heads on both sides of the issue, it is ridiculous to think of any idea of 'book burning.'

"I think NIDA is doing the right thing in trying to protect the health of the American people by saying: 'Look, we know this.' Not only that, but the US Surgeon General, the National Academy of Sciences, and WHO (World Health Organization) have all expressed legitimate concerns about marijuana.

"As a parent, scientist, and policy maker I have to see a lot of issues. I can look at the scientific paper and want to dot the i's and cross the t's, but when you have this particular problem with this particular drug you can't wait another 20 years.

"We have, in dealing with the public, got to get out of using scientific jargon: 'we think,' 'we feel,' 'there is a distinct possibility,' and, 'under theoretical conditions this might occur.'

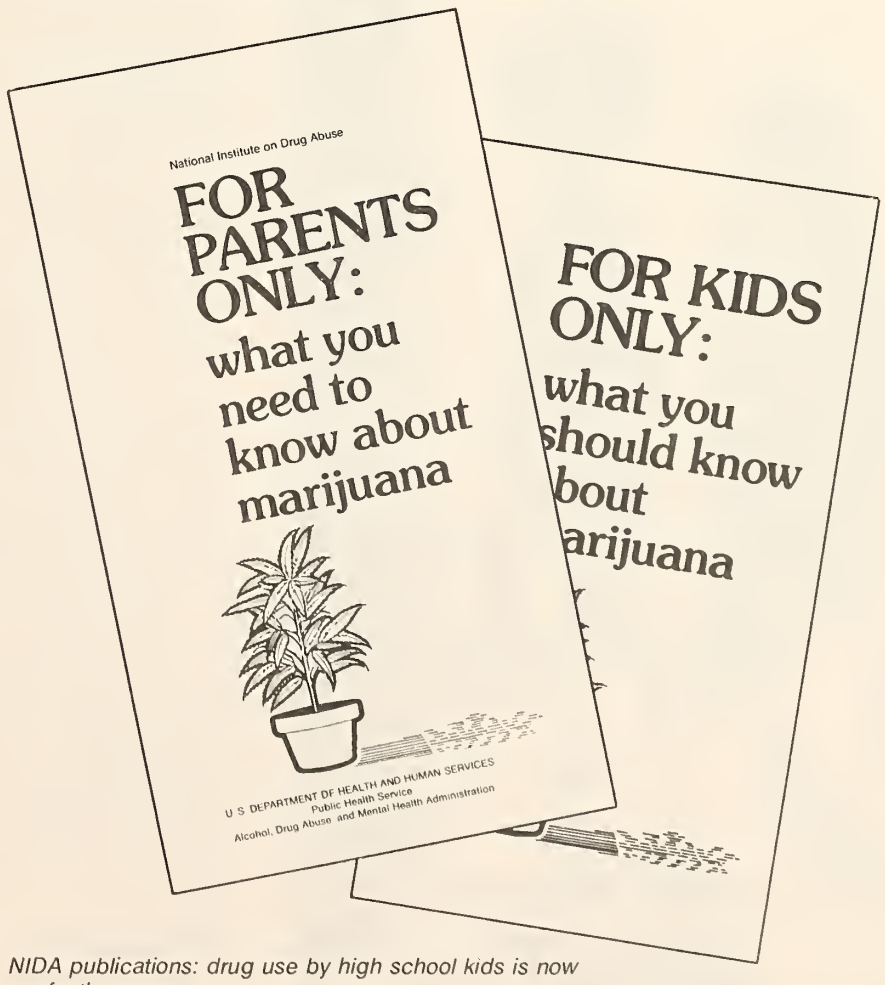
"The results of multiple drug use, and not just marijuana, are happening in the clinics. Remember thalidomide: we scientists didn't find the problems with thalidomide, the clinicians found them.

"In the past, we tried to communicate with parents in a teacher's language, and with kids in adult language. We talked about hard drugs and soft drugs, as if soft drugs were like a soft drink. Look where that got us.

"I think the professionals and the parents have to come together, but some professionals don't want to get involved. In the past, many professionals told the parents to stay the hell out and let them handle it, and we professionals have done a lousy job. So I view the parents as helping the professionals instead of harming them.

"As for pressures, the pro-drug people put tremendous pressure in the past. Now, NIDA, the federal government, Congressmen, and parents want to try and stop drug abuse, and I think have a legitimate right to express their concern.

"It seems that when pro-drug people put pressure on NIDA, nobody got upset. Now let parents and others put on pressure and some people get upset."



NIDA publications: drug use by high school kids is now par for the course

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Pot laws should reflect realities of use: OMA

I read the article — Doctors urged to warn of cannabis hazards (**The Journal**, Aug).

My reason for writing is the last sentence in the article which states: "The OMA (Ontario Medical Association) policy on cannabis continues to be that there should be no change in legislation that will encourage its use." This policy was approved in 1980. Since then the Committee on Public Health has continued to study the issue of cannabis, and added to it in 1982.

The Public Health Committee's report to Council included four recommendations that were approved and now constitute OMA policy. They were:

1) That there be more education of the general public about the harmful effects of cannabis;

2) That there be more education of the medical community about the health implications of cannabis and its effects on populations at risk with underlying medical illness;

3) That the current laws be adjusted to reflect the realities of use so that the effects of exercising the law do not turn out to be more injurious to the individual than the harm that comes from occasional use of low levels of cannabis; and,

4) That there be funding for systematic prospective studies into the medical effects of the use of cannabis, particularly in those suspected of being at greater risk such as women of child-bearing age.

I would point out recommendation #3 which represents an extension of OMA policy over the 1980 statement.

John Krauser, MA
Associate Director
Health Services
Ontario Medical Association
Toronto

Alcohol marketing report commendable

The June issue of **The Journal** carried an excellent report by Richard Gilbert on the Third Canadian Beverage Marketing Seminar. I would like to commend him on the quality of the reporting and also would like to note that **The Journal**'s coverage was the most extensive that any related periodical has given to this premier conference.

As sponsors and organizers of this annual seminar, we always are interested in expanding our market and will keep you informed of when the 1984 seminar will take place. I agree with Dr Gilbert's perspective that members from organizations who are involved in the research and education of alcohol and other drug dependence problems should attend this type of forum to understand how the industry sees itself.

Once again thank you for such fine coverage.

Robert G. Shoniker
Management Resource Group
Toronto, Ontario

Heroin trials unnecessary Cdn pharmacists maintain

In July, **The Journal** carried an article entitled Narcotic clinical trials set to help resolve heroin use for pain management.

The article states, "both the Canadian Society of Hospital Pharmacists (CSHP) and the Canadian Cancer Society have argued against legalizing heroin."

While I can only speak for CSHP, this stand has been taken *not because* "it leads to break-ins in the hospitals and that drugs would get into the hands of drug addicts," as stated in the article. It is because there is absolutely no clinical evidence to substantiate that heroin is superior to any of the drugs currently available. There is, however, considerable clinical data which supports the fact that, if properly used, the medications now used can and will control almost all cases of pain.

During the past five years, a wealth of new information has been gleaned concerning the whole pain process and pain control. If pain is to be controlled, it is imperative that all involved members of the health care professions become fully aware of this information and start to use those drugs available to their maximum potential.

As hospital pharmacists who are vitally concerned with quality patient care, we cannot emphasize too strongly the need to learn to use effectively those medications which are available. It is our belief that at the expense of more pain and suffering we should not be wasting valuable health care time and resources trying to prove the superiority of a drug which has already been shown to have no distinct advantages.

The following are but two of the numerous studies and reports that have been made:

1. Robert Kaiko: Analgesics and Mood Effects of Heroin and Morphine in Cancer Patients with Post Operative Pain, *New England Journal of Medicine* Vol 304, p 1,501, June 18, 1981.

2. Louis Lasagna: Heroin — A Medical Me Too (Editorial), *New England Journal of Medicine*, Vol 304, p 1,539, June 18, 1981.

I do hope this helps to clarify why the society has taken the stand it has.

Donna M. Shaw, BScPharm
Executive Director
Canadian Society of Hospital Pharmacists
Toronto, Ontario

Minister values TJ's information

While I receive a number of periodicals — most relating to theology — **The Journal** has to be rated by far as top-of-the-list in value as far as my ministry is concerned.

I do a lot of work in the area of addictions: public addresses, special classes in schools and universities, group work at a rehab centre, etc. **The Journal** keeps me abreast of current findings and programs, keeps me aware of when and where there are continuing education events, conferences, etc. It also provides information regarding research and how and where to obtain the current literature, plus much, much more.

Last, but certainly not least, I now have 13 years of complete sobriety. During those 13 years I went to university for the first time and became ordained as a minister in the United Church of Canada in 1975.

I sincerely state that **The Journal** has been a good friend in that time and is at least a contributor to my new lifestyle. Thanks.

Rev Gordon Fraser
Middleton, Nova Scotia

Prison doctors walking fine line in medication/sedation balance

By Anne Kershaw

OTTAWA — The prison psychiatrist walks an ethical tightrope in attempting to meet the legitimate medical needs of inmate patients and responding to pressures from security staff.

The use of psychotropic or "mood-altering" drugs in the treatment of disturbed and violent prisoners was a major issue at the 2nd World Congress on Prison Health Care held here recently.

Conference participants from around the world noted and unanimously condemned the use of prison medical staff for unethical practices such as torture, capital punishment by lethal injection, "pain as punishment," and the medication of prisoners for control purposes.

However, prison physicians continue to face the more obscure ethical questions: how to treat the special psychiatric illnesses that accompany incarceration, and when is medication of prisoners medically justified.

Psychiatrist and prison administration may both recommend tranquillization and sedation of prison patients. However, their rationale for doing so is different, said Alfred E. Fireman, PhD, forensic psychiatrist with the Pinellas County Jail and Sheriff's Department of Florida.

More often than not, administrators seek use of chemicals to quiet down prisoners, he said.

"For them a tranquil jail is considerably easier to operate and to control." In balancing allegiances to the system, and to the inmates, the physician has an ethical dilemma, said Dr Fireman.

"At what point may he be considered to have stopped treating the pain, suffering, or illness of his patient, and started to create a jail of, at best, oversedated or tranquillized inmates, and, at worst, a population of addicted inmates," Dr Fireman asked.

Kjell Bjerver, MD, PhD, a psychiatrist with the Swedish correctional service, said there is a need for a "consistent and well thought out" policy.

"Prison staff have thought it a good idea to give inmates tranquillizers to reduce the risk of violence. This means doctors and nurses have not only been under pressure from inmates, but also from prison staff.

The problem almost exclusively concerns tranquillizers and painkillers which are euphoria-producing, Dr Bjerver said.

In 1979, a Swedish study on the use of tranquillizers at certain prisons documented extremely high consumption of sedatives — up to 131.78 daily doses per 100 inmates.

A follow-up study in 1982 showed considerably lower consumption of medicine.

Dr Bjerver said that while the discrepancy was explained partly by differences in method, "one cannot ignore the fact that knowledge that an investigation was going on must have had a restraining effect (on physicians)."

Since the investigation ended, there has been a tendency for consumption to increase, Dr Bjerver said.

One consequence of the findings was that Sweden's National Prison and Probation Administration set up a medicine committee which recommended a catalogue of suitable medicines and stipulated chief areas for use.

"It's obvious that one must keep a tight control over consumption, and observations must always be passed on to all staff concerned," Dr Bjerver said.

Apart from the issue of collaboration between healer and punisher, the prison physician must decide when medical complaints from prisoners justify the prescribing of medication.

"The period spent carrying out a sentence is a very painful time for the individual. It involves a number of psychological reactions and depressive features. Anguish and worry are typical and cause a great deal of suffering," Dr Bjerver said.

Symptoms of a psychosomatic nature, involving stomach, heart, and other organs, are also common.

Dr Bjerver: "Often the worry-symptoms which the inmate shows are quite normal reactions to the situation he is experiencing and should not be treated with medicine.

"The doctor often finds himself in an ethical conflict in which humanitarian reasons for prescribing sedatives have been argued by many people. The pressure from inmates to be prescribed tranquillizers has been great."

Dr Fireman said distinguishing between normal responses to imprisonment and real mental illness is the dilemma.

While few physicians argue whether patients with high blood pressure, constipation, and asthma (so-called psychosomatic conditions) should receive medicine, they may be reluctant to prescribe drugs for the psychological symptoms of anxiety or depression, Dr Fireman said.

He said the prison physician must consider the following:

- What are the normal patient responses to the unusual circumstances of incarceration?
- What is appropriate behavior in the crisis and stress of punitive confinement?
- What levels of anxiety, agitation, and anguish can be presumed to be normal stress responses?
- When, if at all, is it ever in order legitimately to be given sedatives or tranquillizing psychotropics?

Inmates: anguish and worry

Said Dr Fireman, the effectiveness of the prison psychiatrist depends more on the establishment of a trusting and confidential medical-professional relationship than on outmaneuvering his patients.

Many prisoners have become dependent on drugs before being incarcerated.

"For them to feel the way they feel without drugs or chemicals, including alcohol, is a new and frightening experience."

But, he said, the physician must not be intimidated by the patient.

While it is relatively easy to take an inmate off habit-forming tranquillizers prescribed by "street doctors," it's more difficult to detoxify the inmate addicted to unprescribed drugs such as heroin, amphetamines, or cocaine. And it's made more difficult by the "myth and folklore" surrounding addiction, Dr Fireman said.

"The addict subculture is replete with stories of the agony of drug withdrawal."

However, he said, experience with several thousand addicts has shown him it is possible to detoxify even the severely addicted with only minimal amounts of replacement methadone or barbiturates and supportive chemicals such as Librium (chlordiazepoxide) and the phenothiazines.

Dr Fireman said the prison physician should take advantage of the special characteristics of the prison setting.

"In few other clinical settings does the physician have the prerogative to so tightly control his patient's environment without psychotropics or sedatives, and be able to flush out hostility to others while they and he are protected from its effects."

UK in danger of making US heroin mistakes

By Harvey McConnell

LONDON — Arnold Trebach worries that Britain, with a rising number of heroin addicts, is making a horrendous mistake by too closely copying United States treatment methods.

What he wants to see "in the United States, Canada, and any large Western country, is for the national government to back away from treatment of addicted people as far as possible."

This would clear the way for introduction of innovative treatment methods, including the right of any licensed doctor to use drugs — including heroin — to maintain or detoxify addicts on an individual basis.

A lawyer once active in the US civil rights movement, Dr Trebach, PhD, is a professor in the School of Justice, and director of the Institute on Drugs, Crime and Justice at American University (AU), Washington, DC. He has studied British and US methods of treating heroin addicts for the past 10 years and expounded his ideas in the recently published book *The Heroin Solution.**

For eight summers he has run a school here on the subject for AU students and other interested parties.

Dr Trebach says he worries "I may be viewed as 'Mr Heroin — use heroin and it will make you better and see God.' I don't feel that at all, but see heroin partly as a helpful drug and partly as a symbol."

In the US, "hysteria and lack of information" preclude any use of heroin for chronic pain or for maintenance of addicts. There is almost a theological concept: 'Addicts are devils worth going to hell, and drugs are the seed of the devil.'

Trebach

Heroin has always been a legal prescription drug in Britain (see inset below) but since 1971 cannot be used to maintain new addicts.

Dr Trebach thinks: "The British are getting tougher and tougher about how they deal with addicts and about how they deal with doctors who deal with addicts. Clinics have tightened up, and although what they are doing is with good intentions, the dominant medical philosophy is that addicts get methadone and psychotherapy, or what has happened in the States (**The Journal**, Sept, July).

"I believe methadone and psychotherapy are excellent for some addicts, but not for all, or at all stages of their addictive career. Some addicts need injectables, and if they don't get them they will go to the streets.

"Addicts are also going to non-clinic doctors, some of whom are wonderful, and some of whom are just in it for the money. And a large number of addicts are turning to the streets because they can't get adequate treatment from the existing establishment."

There is growing conflict and concern in Britain about private doctors providing prescriptions — for a fee — for Ritalin (methylphenidate), and especially Diconal, an opiate analogue, which is a widely-used analgesic in Britain. Home Office figures show that at the end of last year, there were 300 registered Diconal addicts and a further 900 registered heroin addicts who are given Diconal to try to help them come off heroin.

Thomas Bewley and Harold Ghodse, addiction specialists and psychiatrists for three London hospitals, claimed in a recent article in the *British Medical Journal* that private practice doctors may be making up to £100,000 a year from selling prescriptions for methadone, Ritalin, and Diconal to addicts. Addicts finance the fees by selling surplus drugs on the street.

Clients at two clinics reported many private doctors prescribed larger doses than the clinics and were effectively selling drugs for money.

He admits: "It is very difficult to find the line between the honest doctor who is prescribing for addicts, and treating them, and a crook who is using the shield of the doctor's licence and prescription pad to make a lot of money."

Although he worries about the direction the British are taking in treating addicts, at least, and unlike the US and Canada, heroin *can* be prescribed for chronic pain.

Dr Trebach: "When it comes to the organically ill, I think it is obscene to argue that because some people might use a substance recreationally you deny that use to a cancer sufferer or pain victim. That is beyond the pale of civilized discussion, and, while I don't want to be dogmatic, there is no reason in law, medicine, or ethics not to allow this in the treatment of organically-based pain."

As for his idea that governments back away from treating addicts and leave the task to doctors in particular, Dr Trebach says: "It does not mean you jab the addict full of heroin. I think this is just one of the options the doctor should consider in making an individual diagnosis, just like he makes an individual diagnosis for the treatment of other illnesses."

Skilled doctors can manage patients on codeine, or heroin, or methadone, for example, "if they are willing to take the time to learn what their patients' needs are, and to work with them."

He admits it is not a neat solution: "No matter how hard he or she may try, some patients will get more drugs than they use and will sell them on the street. Tracking each patient who does this would be difficult."

And while some doctors will be crooks, and some will get away with it, "I will trade that possibility for the high possibility and probability of a large number of ethical doctors entering the field and feeling they have freedom to treat patients."

Despite the problems he sees here, Dr Trebach thinks that "on balance the British are infinitely more gentle and humane than the Americans. We Americans do many things wonderfully, but there is no doubt of the fact that we are a much tougher country: crime rates are higher, addicts are more villainous, and our reactions are tougher."

Dr Trebach has been called in by top officials in Washington to explain his views. Even his critics, he says, "admit the British system is much better than ours."

**The Heroin Solution*, Yale University Press, 1982.

Heroin — the legal drug

Heroin is a legal drug in Britain and can be prescribed by any doctor to any patient who is not a heroin addict. It is widely used, often in combination with other drugs, in hospitals, hospices, and at home for controlling pain in terminal cancer patients.

Until 1971, heroin addicts could be prescribed maintenance doses, but the advent of the drug culture in the 1960s in parallel with North America, and a few notorious script doctors, brought a change in the law.

Although "old stage" addicts (pre-1971) can still receive heroin, other addicts receive oral methadone at the government-run National Health Service clinics.

Despite the rising number of heroin addicts in Britain, government officials told The Journal there is no question Parliament — whatever government may be in power — will ever countenance limiting the use of heroin for valid medical reasons.

Most addicts obtain their heroin on the street from supplies smuggled in from Pakistan and not by diversion from legitimate sources.

INTERNATIONAL

Oil-treated patients fared better in study

Evening primrose oil may aid alcoholism care

By Mark Rand

LONDON — Oil from the seed of the evening primrose plant can ease alcoholics' anxiety when withdrawing from alcohol and may speed recovery of their liver and cognitive functions.

Evening primrose oil may also provide some protection for the livers of heavy social drinkers.

Those are the implications of a Scottish study presented at the International Conference on Pharmacological Treatments for Alcoholism, held at the University of London.

The results of the double-blind, placebo-controlled trial were presented by Iain Glen, MD, an honorary senior lecturer at the University of Aberdeen and a consultant psychiatrist with the Highland Psychiatric Service, based at Craig Dunain Hospital in Inverness.

The source of the benefits apparently provided by evening primrose oil, Dr Glen said, is one of its fatty acid constituents, gammalinolenic acid or GLA, which makes up about 9% of the oil by weight.

GLA is important to the normal functioning of the body because it serves as a precursor to a number of substances including several of the hormone-like prostaglandins. Normally, GLA is produced from linoleic acid (one of the constituents of many vegetable oils) by the action of an enzyme known as delta-6-desaturase, Dr Glen said. Alcohol, however, seems to block the activity of this enzyme, resulting in a shortfall of GLA.

Supplying extra GLA in capsule form can theoretically get around this problem, Dr Glen explained, adding that GLA is normally found in the human diet in only minute quantities. Other than evening primrose oil, the only significant source of GLA is believed to be breast milk.

In the double-blind trial described by Dr Glen, 83 men and 12 women — all alcohol-dependent — were studied during a three-week period of detoxification from alcohol. All the subjects received traditional medical and therapeutic support for alcohol withdrawal. In addition, approximately half the alcoholics received four, 500mg capsules of evening primrose oil per day while the other half received placebo capsules.

During the three weeks, data were collected on three aspects of the alcoholics' condition: clinical improvement, as assessed both by the alcoholic and by the nursing staff; liver function; and cognitive function.

The clinical assessment included ratings of well-being, sweating, tenseness, tremor, nausea, and hallucinations. When scores from across the detoxification period were averaged, the oil-treated patients did slightly better on 10 of the 12 ratings (six provided by the patient, six by his or her nurses). The oil-treated patients also used significantly less diazepam during the three weeks of the study, supporting the self-ratings and nurses' ratings suggesting that the actively-treated patients were less anxious and less tense.

At the end of the detoxification, for example, said Dr Glen, the placebo patients were still using, on average, 2 mg of diazepam daily while the oil-treated patients were using only a quarter of that.

The oil-treated patients also showed significantly faster recovery of liver function, Dr Glen said, as measured by the presence of two liver enzymes in the blood. The fact the patients receiving evening primrose oil had lower blood levels of gammaglutamyl transferase and alkaline phosphatase at the end of the three weeks, shows their liver cells were quicker to repair themselves and stop the leaking of these enzymes, he explained.

Cognitive function data from the three-week detoxification period also favored the oil-treated patients, Dr Glen said. Those who received the oil scored significantly better on one test of general intelligence and neither better nor worse on five other cognitive function measures.

Of the 95 patients who completed the initial three-day study, 16 were subsequently followed for six more months. These patients remained off alcohol and continued, double-blind, on either placebo (nine patients) or evening primrose oil (seven). They did not undergo any clinical rating but cognitive function data obtained at six months favored the oil-treated patients, who scored significantly better on one cognitive function test and non-significantly better on four of the other five tests used.

"I don't think that much importance can be placed on the three-week (cognitive) results but the six-month data are more significant. The evening primrose group showed a strong trend toward better cognitive results," Dr Glen said.

The apparently greater cognitive recovery in the oil-treated patients probably reflects greater improvement in the functioning of brain cell membranes, Dr Glen said, due to restoration of more nearly normal availability of GLA and its metabolic products.

Liver function tests at six months, however, showed no difference between the two groups of patients. Dr Glen said this was "to be expected," since none of the patients in the two groups were drinking and, therefore, considerable liver repair could be expected in all of them.

An interesting possibility raised by the three-week liver function tests, Dr Glen said, is that primrose oil could have some protective effect on heavy drinkers who don't intend to quit.

Dr Glen said the next step in his research will be a trial involving up to 100 physically-dependent alcoholics, placed either on evening primrose oil or placebo at the time of detoxification and then followed for at least six months.

Comic liquor ads squelched in NZ

By Tony Garnier

WELLINGTON, NZ — The New Zealand Parliament is considering legislation to ban liquor advertising from television.

The legislation was introduced after members of parliament (MPs) became upset at the tone of liquor ads featuring a "Super-Liquor-Man" showing off his powers, and another commercial featuring British comedian Benny Hill as a pirate slashing prices.

Meanwhile, the Broadcasting Tribunal has upheld complaints against both ads and, in the light of the decision, Television New Zealand has withdrawn them.

Proposing legislation to ban all TV liquor ads, a government backbench MP, Dail Jones, said ads featuring the superman figure had gone beyond the pale.

The commercial showed the figure flying into a liquor store and, with flashing green eyes to simulate x-ray vision, seeking out the lowest-priced products.

At the same time, he would tell the nation to be prepared (ie stock up) to "save the nation" at the major sports events that weekend.

After an initial storm of protest, the commercials were cut to 10 seconds and had the Super-Liquor-Man telling people to "take care."

However, government and opposition MPs agreed the "save the nation" suggestion in one of the ads was an abuse of the English language.

Supporting introduction of the legislation, many MPs added there was a need to restrict or ban televised liquor ads because of their alleged contribution to increased liquor consumption and associated social costs.

However, some MPs argued controls should not be imposed by legislation and should be agreed upon and introduced voluntarily by the liquor industry.

The legislation has been sent to a select committee for study and is not expected back in Parliament until November, when the MPs will make a final decision on whether to adopt it as law.

Mr Jones said his main concern was that young people could be influenced by the type of ads which appeared.

Work by the NZ Council for Educational Research has shown adolescence is one of the critical periods for formulating attitudes to liquor, and efforts to increase public awareness of the implications of alcohol abuse should be concentrated on young people.

Other research has shown there is a rapport between what happens on television and many of the people who watch it.

Both the advertisers and the broadcasting corporation should be held responsible for the recent type of advertisement which society would not tolerate, said Mr Jones.

Trudeau, Cranston: wine toast won't be seen

Ontario too puts end to celebrity wine promotion

TORONTO — A decision by the Liquor Licence Board of Ontario (LLBO) has forced cancellation of a wine advertisement featuring the Canadian Prime Minister's estranged wife, Margaret Trudeau, and champion figure skater, Toller Cranston.

Willis Blair, chairman of the LLBO, said the decision to ban the ad, which shows Ms Trudeau and Mr Cranston holding glasses of wine, is consistent with the LLBO's policy of not allowing celebrities to be used "in the promotion of alcoholic beverages."

The LLBO's decision came too late to halt publication of the ad in the September issue of *Toronto Life* magazine.

Bill Samotie, president of Samotie and Associates, the agency that produced the ad at a cost of $25,000, said the magazine had already gone to press.

Mr Samotie blamed the Board for conditionally approving his preliminary design for the ad; Mr Blair said the agency should have been aware of provincial regulations governing liquor ads.

Arab league states seeking policy to halt heroin boom

By Thomas Land

VIENNA — Twenty Arab countries threatened by the dramatic current increase in opium production in the Golden Cresent of the Middle East are seeking a joint policy to stem the tide.

Many regional and international organizations are assisting in the effort, as well as the governments of Australia and Western Europe and North American countries, whose prosperous black markets for heroin provide the principal financial incentive for the opium-poppy growers.

The Golden Crescent comprises part of Pakistan, Iran, and Afghanistan. Recent changes in the political and market forces affecting the region have led to the production of an estimated 80 tonnes (88.1 tons) of top-quality heroin-base ready for shipment (**The Journal**, July). An illicit drug trade of such magnitude threatens all societies connected with it — including the producers, the consumers, and the transit zones — with corruption and violence as well as the disastrous medical effects of narcotics.

Hence, the decision of the League of Arab States to seek collective protective action. Working in cooperation with the Vienna-based United Nations (UN) Division of Narcotic Drugs, the league recently brought together teams of medical, legal, and law enforcement specialists from its member countries for a confidential 10-day meeting in Tunis.

The meeting was described officially as a "training seminar." In effect, a UN organizer explained, it was intended "to produce a forum where participants and lecturers can freely exchange views on national systems of drug control and the way these systems could most effectively support a global strategy."

Similar "training seminars" have been held for lesser trouble spots, such as the Caribbean and the Far East regions, leading to informal but effective inter-governmental cooperation against the elusive and flexible drug smuggling organizations.

The lecturers addressing such specialist audiences are carefully chosen international authorities in their fields from Australia, Britain, Canada, and the United States. The organizations that regularly make their expertise available to such meetings include the International Narcotics Control Board, the World Health Organization, the UN Fund for Drug Abuse Control, and Interpol.

The Golden Crescent is one of the world's major sources of illegal heroin. Wars and other disasters plaguing the region over the past several years have destroyed a series of cultural, political, and market forces traditionally restraining opium production there. During 1981, the Golden Crescent was the source of 80% of the heroin seized by the law enforcement authorities worldwide.

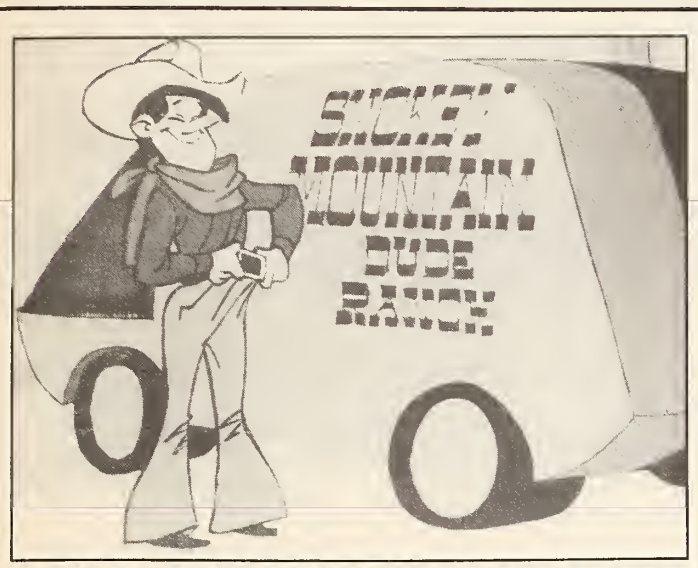
A UN specialist adds: "This pattern of heavy and consistent seizures of illegal opiates from the region has continued throughout 1982 and beyond. The effect of such seizures in reducing the supply of illicit drugs to Australia, Western Europe, and North America is incalculable." However, they have failed to affect significantly the volume of heroin consumption in the producing countries and their close neighbors.

Although the crime syndicates exploiting the opium production boom of the Golden Crescent are essentially concerned with Western hard-currency profits, their activities have led to a widening addiction disaster within the Middle East.

Opium abuse in Pakistan, for example, has recently reached epidemic proportions, according to new government statistics. An estimated one million addicts in Karachi alone are said to consume 88 lbs of heroin daily.

The Pan-Arab Bureau for Narcotics Affairs of the Arab League's Organization for Social Defence Against Crime wants to arrest the spreading disaster through the development of informal contacts among the narcotics specialists of the member countries. It faces an uphill struggle.

The UN specialist explains: "Several countries of the region are taking cooperative measures to prevent drug dependence and to treat abusers. Many countries are also strengthening their law enforcement capabilities, and seizures of substantial quantities of heroin and of clandestine laboratories have been made. An increasing danger is that these laboratories used for the conversion of opium into heroin are becoming ever more sophisticated and produce a drug of very high quality."



Award winner: Smoking: The Choice is Yours has been racking up awards on both sides of the Atlantic — most recently from the British Medical Association, the British Life Assurance Trust, and the Rehabilitation Film Festival in the United States (second place in the prevention category). The 11-minute cartoon was produced by Walt Disney Educational Media.

Drinkers' spouses entering hospital for psychotherapy

AUCKLAND — A New Zealand hospital has reported encouraging results from a novel approach to treating alcoholism — admitting the spouses of alcoholics for a six- to eight-week therapeutic program.

Queen Mary Hospital at Hanmer Springs admitted 38 family members — mostly wives of alcoholics — in the first two years of its family members' program. In about a quarter of the cases, admitting the family member broke the alcoholic's denial and resulted in long-term sobriety.

The program was developed to help family members who had become depressed, suicidal, or demoralized, and who did not seem to be reached by community-based organizations such as Al-Anon.

Besides individual and group therapy, the spouses receive intensive alcohol education and therapies including grief resolution, assertiveness training, social skills, and psychodrama.

At follow-up, 15 of the 38 said they were living with their alcoholic spouse but handling life better. A further 14 had separated, but viewed this as a positive outcome.

"Thus 76% of family members reported what they considered to be favorable outcomes," the medical superintendent, Dr R.J.M. Crawford, reported in the *New Zealand Medical Journal* (July 13).

"These preliminary figures are encouraging," he said. "They represent achievements with patients who have not been assisted by community-based arrangements as at present developed.

"The need for hospitalization may be questioned, but if the psychotherapies are viewed as working by means of alleviating demoralization, it is certainly my opinion that the negative power of the home situation is often too great to be combated by out-patient therapy. Physical separation for a period may be the only way that the family member can recover her self-worth."

Dr Crawford said there is also a need for long-term research into whether such treatment can prevent alcoholism developing in the children of alcoholic families.

Alcoholic denial just a myth says counsellor

By Alan Massam

LONDON — One of the most successful counsellors in Britain believes alcoholics are not as reluctant to acknowledge they have a problem as is commonly believed.

Mary Bruce, director of the London Council on Alcoholism, told **The Journal**: "I think it is a myth that alcoholics are difficult to persuade that they have a problem.

"The information we have suggests such people are asking for help. It is one of the myths that has been around for a long time. The psychiatric services say people don't ask for help, but that isn't true. We are certainly finding that people are coming in. And, there is evidence they have asked other people for help."

Ms Bruce said the London Council, which was set up in 1975, has significantly expanded since the early days.

Alcoholism problems are escalating, and family physicians are not generally well equipped to deal with them.

Ms Bruce said she is keen to catch alcoholics early. Those with a modest problem might be persuaded to look at the underlying cause and perhaps modify their behavior.

She does not automatically propose joining Alcoholics Anonymous because people with early dependency can not identify with alcoholics who have, perhaps, been afflicted for a long time, she said.

NEWS

Elementary schools target of campaign

Drug-using kids are getting younger

By Eleanor LeBourdais

VANCOUVER — The Alcohol and Drug Education Service (ADES) here has received a $22,500 grant from the Vancouver Foundation to be used in preventive educational work in the elementary school system.

The ADES, a non-profit society funded since 1952 by the provincial government, offers a voluntary program — called Making Decisions — for British Columbia schools, which promotes classroom discussion about alcohol, tobacco, and other drug substances. During the 1982-83 school year, about 20 elementary schools in Vancouver, Burnaby, and Coquitlam participated in the Making Decisions program.

The grant will enable the ADES to implement a new preventive drug program for students at the grades six and seven levels. Colin Mamgham, provincial director for the ADES, says elementary school is not too soon to have students discussing alcohol and drug use and abuse, because drug users in the province are getting younger.

A May, 1982 Gallup youth survey prepared for Health and Welfare Canada found that BC has the highest number of adolescent marijuana users of all the provinces. Some 46% of youths less than 20 years of age reported having tried marijuana at least once prior to high school graduation. The prairie provinces were next in the survey at 28%; Ontario reported 26%; the Atlantic provinces, 20%; and Quebec 18%.

The Gallup survey also revealed that BC had the lowest age at which adolescents first experimented with marijuana — 13 years.

Lower Mainland high schools currently incorporate drug education into their guidance and health classes, but counsellors don't have a set curriculum. The majority of the counsellors are aware alcohol and drugs have become a part of the student lifestyle but say most consumption occurs away from the school premises on weekends or at parties.

Counsellors at Eric Hamber Secondary School estimate that up to 50% of the students experiment with marijuana before reaching grade 12, but that alcohol becomes more the "opiate of choice" once students look old enough to gain entry into bars, says counsellor Claire Cummings.

Bob Lewis, a counsellor at David Thompson Secondary School, believes the level of drug use is lower than it was in the 1970s.

Most high schools have liaison officers who work with the school administrations. If a student is caught "stoned" or in possession of drugs, he or she is immediately transferred to another school, in accordance with school board policies in the Lower Mainland. Police only get involved in cases of possession.

In 1981, the most recent year for which Statistics Canada figures are available, 460 juveniles were charged with possession or trafficking in BC under the Narcotic Control Act, ranking second behind Ontario, which had 583. Quebec was third with 409.

Constable Jerry Poitras of the Abbotsford Royal Canadian Mounted Police squad, thinks drug use in schools is about the same in all communities. "You can't say it's worse here or there. The individual school will reflect availability in the community. The larger the school, the larger the community, the larger the problem."

NB tallies economic losses of alcohol abuse

By John Carroll

FREDERICTON — Economic losses resulting from alcohol abuse in New Brunswick outstrip the net income of the NB Liquor Corporation (NBLC) by three to one, a recent study reveals.

The study was carried out by the research and evaluation division of the Alcoholism and Drug Dependency Commission (ADDC) of New Brunswick. It estimates alcohol abuse brought an economic loss in 1981-82 of $156.2 million. (The annual report of the NBLC for the fiscal year ending March 31, 1982, shows total sales were $156,085,499, with net income of $51,896,559 [**The Journal**, April, 83].)

The ADDC study examined seven factors — costs of health care, social welfare, lost production, and motor vehicle accidents, as well as fire losses, crime, and social responses to alcohol abuse.

Offsetting the costs to society of use and abuse of alcohol, the research division acknowledged "the production, sale, and control of alcoholic beverages provides substantial government revenue, as well as providing jobs and revenue in the public sector."

In 1978-79, total revenue from the sale of alcohol was nearly $43 million, or $61.38 per capita. The study used a rounded-off population figure of 700,000. (The 1981-82 NBLC annual report says, based on a population of nearly 689,000 people, total sales were $226.56 per capita, while net income was $75.32 per capita — an increase of 22.7% in three years.)

In fiscal 1981-82, the study found that residents aged 15 years or older consumed 9.65 litres of absolute alcohol per person. While this represents a slight decrease from a year earlier, the study says total consumption has risen approximately 23% in the past 10 years.

The study states that 13% of the adult population's expenditures on hospitals, doctors' services, drugs, and nursing homes — about $54.7 million — are the result of alcohol abuse. New Brunswick has an estimated 20,000 alcoholics.

Using a conservative estimate of 20% of social welfare services being attributable to alcohol abuse, the study says the government spent nearly $31.8 million dealing with alcohol-related social and family problems.

On lost production, an estimated 11,800 members of the 296,000 member labor force — about 4% — would be considered alcoholics or problem drinkers.

"Alcohol-abusing employees have been shown to be absent more often than non-abusers, to have higher accident rates, to use more sick leave benefits — in total, to be functioning at a rate 25% lower than potential capacity."

The study says 25% of the wages paid to alcoholics or problem drinkers in the work force were lost, costing employers $52.7 million.

Using motor vehicle accident statistics for 1981, the study says "alcohol abuse was responsible for approximately 75 deaths, 735 people injured, and $2.5 million in property damage."

Findings indicate that 48% of deaths, 17% of personal injuries, and 7% of property damage from fire are the result of alcohol abuse. Statistics for 1980 — the latest available — attribute 15 deaths, four injuries, and $1.1 million in property losses to alcohol abuse, the study says. Another $5.3 million can be added when gross firefighting expenditures are considered.

The study says alcohol-related crime cost New Brunswickers in excess of $3.6 million. Alcohol was a factor in 1,412 reported offences such as homicides, sex crimes, and assaults.

In terms of social response costs — treatment and rehabilitation of abusers, and development of prevention, education, and research programs — the study points to the ADDC 1982 budget of $4.5 million as the direct cost in this area.

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Patients following R_x rules getting hooked on tranqs

By Betty Lou Lee

HAMILTON — Many benzodiazepine users don't know they are addicted to the tranquillizers until they stop them or cut down and go into withdrawal.

And they may have been taking no more than their doctor prescribed, says Doreen Birchmore, therapist at the Donwood Institute in Toronto, an addictions treatment centre.

"We also get alcoholics admitted to Donwood who get through alcohol withdrawal then go into Valium (diazepam) withdrawal, which is more serious and takes longer to recover from. It happens very, very often," she told the 24th annual Institute on Addiction Studies held at McMaster University by Alcohol and Drug Concerns, Inc of Toronto.

She said some doctors still do not believe addiction is possible on prescribed amounts of benzodiazepines, but some patients can become physically dependent in two weeks.

Gender, age, smoking history, liver disease, and use of other drugs can all have a bearing on the development of dependence. Smokers require 50% more of the tranquillizers for equivalent action, and Antabuse (disulfiram) and Tagamet (cimetidine) inhibit the discharge of Valium from the body.

Withdrawal symptoms can start from a few days to 10 days after stopping the drug, depending on the half-life of the particular product, and can last up to six weeks. Symptoms include vision changes, headaches, sleeplessness, confusion, internal and external shaking, fears, panic attacks, poor memory, and inability to concentrate. It may be months before the last two symptoms return to normal.

In severe cases, seizures, hallucinations, and convulsions are possible.

Call for abstracts

CALGARY — Deadline is December 31 for abstracts of papers for the Canadian Public Health Associations (CHPA) 75th annual conference to be held here June 25-28, 1984.

Theme is 'Kaleidoscope.' Scientific papers; audio-visual, educational, and promotional materials; commercials, and posters are sought on topics dealing with public health, public policy, and future planning.

Contact: Scientific Program Committee, c/o Canadian Public Health Association, Ste 210, 1335 Carling Ave, Ottawa, ON K1Z 8N8.

Jail a 'bankrupt solution' for Kenora's alcohol offenders

By Mark Kearney

TORONTO — The Ontario government is spending approximately $1.3 million annually to incarcerate fine defaulters for provincial and federal offences — mostly alcohol-related — in the Kenora District Jail.

And at least eight out of every 10 offenders will likely be convicted of another liquor offence within a year, says a report to the Ontario Native Council on Justice. The report was written by Stan Jolly, director of policy and program development for the council, and Joseph Peter Seymour, executive director of the Ne-Chee Friendship Centre.

Mr Jolly says he's optimistic the government will respond quickly to what has become an "almost crisis" situation in the Kenora area. (**The Journal**, Nov 79, Aug 81)

The government has approved funding for establishing a community corrections worker project on the Rat Portage reserve, he says. The province is also studying a proposal to set up a wilderness camp in the area as an option to jail.

The camp could be set up as early as next spring and would allow the offender to explore his or her Native identity, Mr Jolly told **The Journal**. The offender would fish, hunt, trap, and do other work on the camp while receiving lifestyle and alcohol education.

"I'm more optimistic now than I have been in the last few years that there is a willingness on the part of the government" to improve the situation in Kenora, Mr Jolly says.

Other options being considered are a Native alcohol treatment centre, a hostel/shelter for people intoxicated in public, and a program permitting the payment of fines for provincial offences by credit for work performed.

The report was done in response to the high rate of Native incarceration in Kenora and the large proportion of Liquor Licence Act charges there: five times the proportion elsewhere in the province.

The provincial court in Kenora also sentences alcohol law violators to jail three times as frequently as courts in the rest of Ontario. On average, 40 fine defaulters and 15 sentenced offenders are incarcerated each month for such offences, the report says.

Mr Jolly says it's difficult to determine why the situation became so serious, but a certain negativism developed in the area because of the high rate of public intoxication there. The Kenora police commission also decided a few years ago that detoxification wasn't solving the problem, he adds.

Nevertheless, the high rate of recidivism in the area for alcohol-related offences demonstrates that "incarceration is a bankrupt solution to the problem of fine default and public intoxication."

Mr Jolly says decriminalizing some of the liquor offences, particularly public intoxication, could be considered by the government.

"When a cultural and racial minority appears to be engaging in such massive, albeit unintentional, civil disobedience, does that not raise the doubt about the propriety of the law itself?" the report asks. "In other words, should public intoxication be a crime? Are the consequences for criminalization worse than the offending behavior?"

Substance abuse and the privileged

Manuscripts called for

NEW YORK — *Advances in Alcohol & Substance Abuse*, published by The Haworth Press and edited by Barry Stimmel, MD, dean for academic affairs at New York's Mount Sinai School of Medicine, invites those interested to submit manuscripts for a planned special issue. Focus of the issue is: Substance Abuse and the Privileged; Clinical Issues in Treatment.

Papers should deal with clinical problem areas in addicted or alcoholic clients in privileged socioeconomic classes, including the highly-educated, the highly-cultured, and the well-to-do, says Dr Stimmel.

Suggested topics include cocaine and the arts, criminal justice, special services for white-collar abusers, health professionals and alcohol or substance abuse, and ethical or legal issues facing practitioners who treat the privileged.

Outlines should be sent by December to: Barry Stimmel, MD, Editor, Advances in Alcohol & Substance Abuse, Dean for Academic Affairs, Mount Sinai School of Medicine, Annenberg 5, 1 Gustave L. Levy Place, New York, NY, 10029.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Margaret Sheppard, at (416) 595-6150.

Who Cares

Number: 564.
Subject heading: Attitudes and values.
Details: Three 10-min segments, ¾" video, color.
Synopsis: These three segments of a five-part series show: (1) the reenactment of a school playground accident and children relating how they learned what to do in the event of an accident; (2) a collage of children's activities through which they can feel good about themselves; and (3) a question and answer session with children expressing what they feel about alcohol and other drug use.
General evaluation: Fair (3.4). The accident sequence was informative. However, the discussion session about drugs seemed boring and not helpful.
Recommended use: Of benefit to children eight to 11 years, with a resource person.

No Time At All

Number: 572.
Subject heading: Drugs and youth.
Details: 20 min, color.
Synopsis: Many groups and singers come and go in the Country and Western field. Many performers have not lasted, even though very talented, because they abused alcohol and other drugs. Interviews with several Country and Western stars point out the many dangers of drug use and the benefits of non-use.
General evaluation: Fair (3.0). This film seemed out-of-date. The interviewer supplied the answers to his own questions. The film seemed disjointed with no clear focus.
Recommended use: Intended for teenagers, but would probably not have an impact on them.

What Is Your Health Hazard Risk?

Number: 574.
Subject heading: Lifestyle.
Details: Three 15-min filmstrips and cassette tapes, color.
Synopsis: The first two filmstrips deal with fitness and nutrition. The third is a checklist asking viewers to respond to questions about their drug use. The narrator then explains why the use of drugs is incompatible with a healthy lifestyle.
General evaluation: Poor to fair (2.6). Some of the multiple-choice questions were poorly designed. The pictures were considered unimaginative.
Recommended use: Could be used by those 15 years and older.

Another Chance

Number: 576.
Subject heading: Alcohol and the family, treatment/rehabilitation.
Details: 28 min, 16 mm, color.
Synopsis: People who have lived with a family member who is dependent on alcohol often feel resentment, anger, guilt, neglect, and many other potentially destructive emotions. Through a reenactment of their interactions with the problem drinker and a working out of their emotions, the children of alcoholics can be returned to a healthier frame of mind. This therapy technique is illustrated by one woman reliving many of her life stages and coming to terms with her emotions.
General evaluation: Fair (3.1). The audiovisual assessment group was reluctant to endorse this film for general audiences because the therapy technique shown requires skillful handling and should not be used indiscriminately. The group also considered the characterizations sometimes confusing, although the film had high emotional impact.
Recommended use: For professional training, with a resource person.

DEPARTMENT

New Books by RON HALL

Etiologic Aspects of Alcohol and Drug Abuse

. . . edited by Edward Gottheil, Keith A. Druley, Thomas E. Skolada, and Howard M. Waxman.

This book is the result of the 4th Annual 1980 Coatesville-Jefferson Conference on Alcohol and the Addictions. It is organized along traditional lines of discipline with biological, sociocultural, and psychological sections. The opening chapter presents two research strategies which stress the significance of genetic factors in alcoholism, twin studies and marker studies, and is followed by a third approach, adoption studies. This is followed by a chapter dealing with the rationale, strengths, and limitations of animal models as total models of addiction. A combination of ideas concerning opiate addiction, tolerance, and withdrawal are presented next. The final chapters in the first section deal with ethanol metabolism and its effect on organ systems and the biological consequences of alcoholism, specifically the effects of alcohol and acetaldehyde on albumin production and secretion. In the second section, the major emphasis is on the psychological-behavioral aspects of substance abuse. The first two papers concentrate on the unconscious aspects of addiction and relate addiction to contemporary psychodynamic concepts. A review is presented of the behavioral approach, which states that substance abuse is operant behavior, controlled and maintained by its consequences. The topic of the temporal ordering of the consequences of drug use is addressed and an overview of the social-learning influences on alcoholism is presented. The last two papers in this section do not confine themselves to the psychological, but consider the psychological factors in interaction with the biological and social. Specific subtypes of substance abuse are described and the ways in which personality traits, biological dispositions, and cultural influences may lead to dependence upon drugs or alcohol. The third section of the book describes the contributions of sociocultural factors to the etiology of substance abuse. The section opens with an overview of sociocultural factors related to the etiology and definition of addiction. The next paper presents a discussion of the significant reduction in the use of drugs and alcohol among young people who joined either of two contemporary American religious sects. Two papers focus on the family and familial factors related to substance abuse. Two chapters are devoted to Alcoholics Anonymous. The final paper is the description of a research project where patients were given the opportunity to drink or not drink alcohol as part of a special program on an alcohol treatment and research ward.

(Charles C. Thomas, 2600 S 1st St, Springfield, IL 62717. 1983. 330p. $39.75. ISBN 0-398-04732-4)

Statistics on Alcohol and Drug Use in Canada and Other Countries

. . . Addiction Research Foundation

This is the fourth report in a series of statistical reports formerly entitled Statistical Supplement to the Annual Report of the Addiction Research Foundation. It is intended to provide the reader with a broad overview of the nature, extent, and consequences of the use of psychotropic substances in Canada, and in Ontario in particular, as well as presenting a brief overview of international trends. The major substances covered are alcohol, other psychotropic drugs (both licit and illicit), tobacco, and caffeine. For all four categories, available information has been presented to give an indication of levels of consumption or use; health problems, both physical and psychological, and including mortality and morbidity; events pertaining to the area of law enforcement; and the economic importance to our society of these substances.

(Addiction Research Foundation, Marketing Services, Dept RH, 33 Russell Street, Toronto, Ontario M5S 2S1, 1983. 324 p. $23.50. ISBN 0-88868-076-7)

Other books

How Much is Too Much? The Effects of Social Drinking — Gross, Leonard. Random House, New York, 1983. Moderate drinking; cirrhosis, cancer, and hypertension; birth defects and synergistics; cognition controversy; threshold drinking; meaning of surveys. Index. 160 p. Random House NY, NY 10022. $10.95. ISBN 0-394-52726-7.

Alcoholism and the Family: A Guide to Treatment and Prevention — Lawson, Gary; Peterson, James S.; and Lawson, Ann. Aspen Systems, Rockville, 1983. Etiological theories of alcoholism; treatment approaches; viewing the family as a client; diagnosis of the alcoholic family; prescription for family treatment; related problems; children of alcoholics; art therapy; treatment with the alcoholic's spouse; public health model; prevention. Index. 296 p. Aspen Systems, 16792 Oakmont Ave, Gaithersburg, MD 20877. ISBN 0-89443-674-0.

Alcohol Abuse: Geographical Perspective — Smith, Christopher J. and Hanham, Robert Q. Association of American Geographers, Washington, 1982. Uses and abuses of alcohol; society, culture, and drinking behavior; alcohol epidemiology; prevention and control of alcohol abuse. Bibliography. 84 p. Association of American Geographers, 1710 16th St NW, Washington, DC 20009. $5. ISBN 0-89291-166-2.

Recovery: Stories of Alcoholism and Survival — Stromsten, Amy. Rutgers Center of Alcohol Studies, New Brunswick, 1982. Collection of 47 photographs by the author and personal stories of alcoholics. 143 p. Rutgers Center of Alcohol Studies, New Brunswick, NJ 08854. $20. ISBN 911290-14-1.

Student Drug Use, Attitudes, and Beliefs: National Trends 1975-1982 — Johnston, Floyd D.; Bachman, Jerald G.; and O'Malley, Patrick M. National Institute on Drug Abuse, Rockville, 1983. Prevalence of drug use; recent trends in drug use; use at earlier grade levels; degree and duration of highs; attitudes and beliefs about drugs; social milieu. 134 p. US Government Printing Office, Washington, DC 20402.

Black Alcoholism — Watts, Thomas D. and Wright, Roosevelt, Jr (eds). Charles C. Thomas, Springfield, 1983. Etiological factors in alcoholism among Blacks; treatment; primary and secondary prevention; research, policy, and practice issues. Appendix; index. 242 p. Charles C. Thomas, 2600 S First St, Springfield, IL 62717. $26.75. ISBN 0-398-04743-X.

Current Controversies in Alcoholism — Stimmel, Barry (ed). Haworth Press, New York, 1983. Patients who refuse study; group therapy with alcoholic clients; indicators of alcohol-related mortality; marijuana use in alcoholism; alcohol use during pregnancy; selective guide to reference sources on topics discussed. 82 p. Haworth Press, 28 E 22nd St, New York, NY 10010. $19.95. ISBN 0-86656-225-7.

Report of the International Working Group on the Single Convention on Narcotic Drugs, 1961 — Addiction Research Foundation (ARF), Toronto, 1983. Report arising out of a meeting sponsored by the ARF, International Council on Alcohol and Addictions, and the World Health Organization, and held Sept 20-24, 1982, in Toronto; text in English, French, and Spanish; controversial issues concerning the effects and effectiveness of the Convention; benefits and problems; conclusions and recommendations. 66 p. Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1. $4.50. ISBN 0-88868-077-5.

DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Addictions '83 International —Oct 12-14, Ottawa, Ontario. Information: Mrs C. Cashman, Coordinator, Postgraduate Board, Royal Ottawa Hospital, 1145 Carling Ave, Ottawa, ON K1Z 7K4.

Detox Training Program (Non-Medical) — Oct 17-21, Nov 14-18, Toronto, Ontario. Information: Diane Hobbs, Detox and Rehab Programs, Addiction Research Foundation (ARF), 33 Russell St, Toronto, ON M5S 2S1.

York-Toronto Respiratory Care Society Update: Respiratory Diseases — Oct 21, Toronto, Ontario. Information: Linda Murca, York-Toronto Lung Association, 573 King St, E, Toronto, ON M5A 1M5.

Gairdner Foundation Lectures — Oct 27-28, Toronto, Ontario. Information: The Gairdner Foundation, Ste 220, 255 Yorkland Blvd, Willowdale, ON M2J 1S3.

Alcohol and Drug Abuse Conference — Oct 27-28, Saskatoon, Saskatchewan. Information: CME office, University of Saskatchewan, 408 Ellis Hall, Saskatoon, SK-S7N 0W0.

New Trends in Pharmacy — The Canadian Society of Hospital Pharmacists 36th annual meeting — Oct 30-Nov 3, Montreal, Quebec. Information: The Canadian Society of Hospital Pharmacists, Ste 303, 123 Edward St, Toronto, Ontario, M5G 1E2.

Pharmacology and Drug Abuse Course — Oct 31-Nov 2, 1983, Feb 6-8, 1984, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Fundamental Concepts Course in Addictions — Jan 16-19, 1984, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Perspectives on Employee Assistance Programming Course — Jan 23-26, 1984, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Annual Meeting of the Ontario Psychiatric Association — Jan 26-28, 1984, Toronto, Ontario. Information: Donna Gray, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

37th Annual Convention of the Ontario Psychological Association — Feb 9-11, 1984, Toronto, Ontario. Information: Dr Pierre Ritchie, Convenor, OPA '84, 1407 Yonge St, Ste 402, Toronto, ON M4T 1Y7.

Toughlove Weekend Workshop for Parents and Professionals — March 3-4, 1984, Vancouver, British Columbia. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania 18960.

1984 Canadian Addictions Foundation Atlantic Regional Conference, Families and Drug Dependencies New Problems, New Challenges — April 29-May 3, 1984, Halifax, Nova Scotia. Information: Nova Scotia Commission on Drug Dependency, 5668 South St, Halifax, NS B3J 1A6.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: Mr J. Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th Floor, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton AB T5J 3M9.

United States

35th Annual Convention and Scientific Assembly of the American Academy of Family Physicians (AAFP) — Oct 10-13, Miami Beach, Florida. Information: The American Academy of Family Physicians — 1740 W 92nd St, Kansas City, Missouri 64114.

Interdisciplinary Approaches to the Issues of the Chemically Dependent Nurse: Areas of Cooperation and Conflict — Oct 15-16, San Francisco, California. Information: Stephanie Ross, Haight-Ashbury Training and Education Project, 409 Clayton St, San Francisco, CA 94117.

Controlled Release Drug Delivery: Theory and Technology — Oct 17-19, East Brunswick, New Jersey. Information: General Information, PO Box H, East Brunswick, NJ 08816-0257.

Seminar on Children and Chemical Abuse — Oct 17-21, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

Chemical Dependency: Children's Issues — Oct 19. **Chemical Dependency: Children's Programming** — Oct 20-21, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Update on Drugs — Oct 19, Charlotte, North Carolina. Information: Tammie Lesesne, Program Development and Public Information, Charlotte Drug Education Center, 1416 E Morehead St, Charlotte, NC 28204.

1983 Postgraduate Course in Clinical Pharmacology, Drug Development and Regulation — Oct 24-28, Rochester, New York. Information: K. Niven, Course Administrator, department of Pharmacology, The University of Rochester Medical Center, 601 Elmwood Ave, Rochester, NY 14642.

Florida Alcohol and Drug Abuse Association 3rd Annual Conference — Oct 26-28, Orlando, Florida. Information: D. Majken Peterzen, 1300 Executive Center Dr, #300, Tallahassee, FL 32301.

3rd Annual Fall Conference "Tools of the Trade" — Oct 26-28, Williamsburg, Virginia. Information: Craig Nuckles, Riverside Hospital, 420 J, Clyde Morris Blvd, Newport News, VA 23601.

Communications and Marketing Conference for Professionals, Treatment Programs and Volunteer Organizations — Oct 28-29, Williamsburg, Virginia. Information: Marcon East, 2100 N 105th, Seattle, Washington, 98133.

Alcoholism in the Black Community: 4th Annual Conference — Oct 29, Newark, New Jersey. Information: ABC c/o RAFT, East Orange General Hospital, 300 Central Ave, East Orange, NJ 07019.

Intervening with Alcoholic and Other Drug Dependent Families — Oct 31-Nov 3, Chicago, Illinois, Nov 29-Dec 2, Orlando, Florida. Information: Joanne Terry, Johnson Institute, 10700 Olson Hwy, Minneapolis, Minnesota 55441-6199.

3rd Annual Primary Prevention Conference "Kid's Stuff II" — Nov 1-3, Austin, Texas. Information: Peggy Frias-Lynch, Prevention Services, Texas Commission on Alcoholism, 201 E 14th St, 8th floor, Austin, TX 78701.

Alcohol and Drugs: Issues in the Workplace — Nov 3-4, Washington, DC. Information: Registrar, Alcohol and Drug Abuse Conference, The Bureau of National Affairs, Inc, 1231 25th St, NW, Ste S-602, Washington, DC 20037.

American Association for the Study of Liver Diseases — Nov 4-7, Chicago, Illinois. Information: C. B. Slack, 6900 Gorve Rd, Thorofare, New Jersey 08086.

Innovations in Alcohol/Drug Abuse Programming Models — Methods — Evaluation — Nov 7-11, Pacific Grove, California. Information: Leslie Nyberg Tamble, Evaluation and Research department, Box 11, Center City, Minnesota 55012.

American Society of Criminology 35th Annual Meeting — Nov 9-12, Denver, Colorado. Information: Joseph E. Scott, department of Sociology, Ohio State University, Columbus, Ohio 43210.

National Conference on Medical Education and Research in Alcohol and Drug Abuse — Nov 10-11, Washington, DC. Information: Dr Charles Buchwald, Conference Coordinator, National Conference on Medical Education, Downstate Medical Center, 450 Clarkson Ave, Box 129, Brooklyn, New York 11203.

Mental Health Section and Forum on Drug and Alcohol Problems, of the American Public Health Association, Annual Meeting — Nov 13-17, Dallas, Texas. Information: Dr David Duncan, Mental Health Membership Chairman, SIU Department of Health and Education, Carbondale, Illinois 62901.

ADPA 1983 Western Regional Conference — Nov 13-16, Los Angeles, California. Information: Eric Scharf, ADPA, 1101-15th St, NW, Ste 204, Washington, DC 20005.

Recent Developments in the Treatment of Disturbed Adolescents — Nov 18, New Hyde Park, New York. Information: Ann Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

2nd Annual National Conference on Alcoholism and the Family, Western Edition — Nov 20-23, San Diego, California. Information: Fam-Con West II, PO Box C 19051, Seattle, Washington 98109.

Toughlove Action Training for Professionals Working with Young People — Nov 30, Philadelphia, Pennsylvania. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, PA 18960.

The 3rd Annual New England Conference on Alcohol Issues, "Trends in Policy and Planning for Alcohol Issues" — Nov 30-Dec 2, Newport, Rhode Island. Information: New England Conference on Alcohol Issues, 755 Boylston St, Ste 306, Boston, MA 02116.

SECAD/8, Southeastern Conference on Alcohol and Drug Abuse — Nov 30-Dec 4, Atlanta, Georgia. Information: Barbara D. Turner, Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, Georgia 30342.

Toughlove Action Training for Professionals Working with Young People — Dec 7, Framingham, Massachusetts. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, PA 18960.

Ruth Fox Course for Physicians — April 12, 1984, Detroit, Michigan. Information: Claire Osman, Course Coordinator, American Medical Society on Alcoholism, 733 3rd Ave, New York, NY 10017.

46th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 4-6, 1984, St Louis, Missouri. Information: Dr Joseph Cochin, department of Pharmacology, Boston University, School of Medicine, 80 East Concord St, Boston, MA 02118.

Abroad

International Drug Conference — Institute — Oct 24-31, Cancun, Mexico. Information: Edward B. Morley, III, Director, Group Travel, Morley Incentives, PO Box 1908, Saginaw, Michigan 48605.

Currents in Alcohol Research and the Prevention of Alcohol Problems — Nov 7-9, Lausanne, Switzerland. Information: Swiss Institute for the Prevention of Alcohol Problems — (SFA/ISPA), PO Box 1063, CH-1001 Lausanne.

4e Colloque national sur la prevention de l'alcoolisme. L'Etat face a l'alcool et aux droques — 10/11 novembre, Lausanne, Suisse. Information: Institut suisse de prophylaxie de l'alcoolisme, Case postale 1063, 1001 Lausanne, Suisse.

9th International Conference on Alcohol, Drugs and Traffic Safety — Nov 13-18, San Juan, Puerto Rico. Information: T-83 Secretariat, GPO Box 5067, Medical Sciences Campus, San Juan, Puerto Rico 00936.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

2nd International Congress on Drugs and Alcohol — Dec 18-22, Tel Aviv, Israel. Information: Congress Secretariat: Peltours Ltd, Congress department, PO Box 394, Tel Aviv, 61003 Israel.

An International Conference on Alcoholism and Drug Addiction — April 2-7, 1984, Canterbury, England. Information: Conference Secretary, Broadway Lodge, Oldmixon Rd, Weston-super-Mare, Avon, BS24 9NN, England.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: Dr H. D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

Campus drinkers: they're on their own

By Gary Lamphier

Each autumn, thousands of Canadian students experience the ritual rites of passage from high school to university. For many, the transition means a new home, new friends, and a new city. But in the lives of those students who consume alcohol — roughly nine in 10 — their new status as freshmen signals another change: increased drinking.

A recent three-part study of post-secondary drinking habits in Canada confirmed a pattern that has already been identified in the United States: alcohol use increases "significantly" once a student enters university.

Moreover, a substantial minority of these students drink "heavily, if not excessively," say the authors of the Canadian study, Michael Goodstadt, PhD, head of the educational research section, program development research department, Addiction Research Foundation (ARF), and Anuppa Caleekal-John, an ARF research assistant.

To date, the subject of university students and booze has drawn little public attention, and the reaction among most university administrators, students, and government bureaucrats has been almost uniform silence.

But there are indications alcohol abuse is slowly becoming an issue on campus. The comments of student affairs administrators at 12 Ontario universities surveyed by Dr Goodstadt and Ms Caleekal-John are telling.

Says one anonymous spokesman: "Very frequently vandalism, rowdiness, and other anti-social behavior is related to excess alcohol consumption."

"In 1982, there were seven cases of vandalism and all seven were alcohol-related," claims another.

"Because this is a residence, the indications of need are fairly obvious," states a third. "People here party a lot and always with booze. Drinking is the social norm. There are a few that can't get jobs, can't stay in school, or can't keep roommates. Those who are also worrisome are the people who sit alone in their rooms and drink a lot."

One university spokesman said 63% of the 36 students who were brought before the school's Judicial Committee during the fall and winter terms admitted to being intoxicated while committing offences including petty theft and assault.

Still another claims: "We see much evidence of public mischief, damage to facilities, rowdy behavior surrounding licenced events, and security reports detailing problems involving individuals who have been drinking excessively. Even our students' union has seen fit to begin an advertising campaign to warn other students about alcohol abuse."

Though Canadian statistics are hard to come by — researchers point out that not one single study has examined drinking habits among the thousands of students who attend Canada's community colleges — the information that is available justifies the concern about student drinking.

"Whereas the prevalence of alcohol use for Canadian university students does not appear to differ greatly from that found for Ontario grade 13 high school students," the ARF researchers say, "the university students' frequency of alcohol use is much greater.

"For example, only 24.1% of grade 13 students in 1981 reported drinking once a week or more frequently, compared to approximately 70% of students in the University of Guelph study (Kennedy and Raudoja, 1977) and the Wilfrid Laurier University (BACCHUS, 1982) study. Similarly, less than 1% of grade 13 students reported drinking almost every day, compared to 6% of the Guelph sample.

"This difference in drinking patterns between grade 13 and university students may be accounted for, in part, by a shift in the legal status — university students are more likely to be 19 years old, the legal limit for alcohol consumption in Ontario."

The authors say US studies mirror the Canadian data: "These (US studies) have all documented the same high prevalence rates of alcohol use, and in some cases alcohol-related problems, documented by Canadian studies. One report (US department of Health, Education and Welfare, 1974) estimated that one of 20 college students are problem drinkers. Blane and Hewitt (1977), in reviewing 68 college surveys, concluded that drinking among US college students has been rising since 1936. Ninety per cent of current students have had a drink, and today's students drink more frequently and become intoxicated more often than today's high school students, and probably more frequently than college students of 25 years ago."

Despite growing evidence that booze is causing problems among Canada's 401,700 university students, most officials remain reticent to discuss the issue publicly: "University officials themselves confirm that alcohol has been a problem," says Ms Caleekal-John. "They have their own confidential data to confirm it. They just don't want to make it public in case they're singled out as the only university with a problem."

Dr Goodstadt says revenues generated by a rapidly-expanding number of student pubs (up 671% from 14 to 94 in Ontario alone between 1974 and 1981) further "muddies the whole scene," discouraging student councils that benefit from these funds from taking remedial action.

Indeed, survey respondents list a number of obstacles to alcohol education programs for students — lack of funds and staff, policy constraints, prejudices, lack of comparative survey data, space limitations, and lack of receptiveness.

Fully 75% of the 12 Ontario student affairs administrators who responded to the ARF researchers' questionnaire offered "unambiguous endorsement" to the need for campus alcohol education programs. Yet, only one — Wilfrid Laurier University — has such a program (BACCHUS — Boost Alcohol Consciousness Concerning the Health of University Students).

This contrasts sharply with the US, where BACCHUS programs alone have been implemented on 95 campuses (**The Journal**, March). In fact, the ARF researchers say Wilfrid Laurier's BACCHUS program is the only permanent alcohol education program on any university campus in Canada, though a number of universities have introduced short-term programs such as Alcohol Awareness Week, and the like.

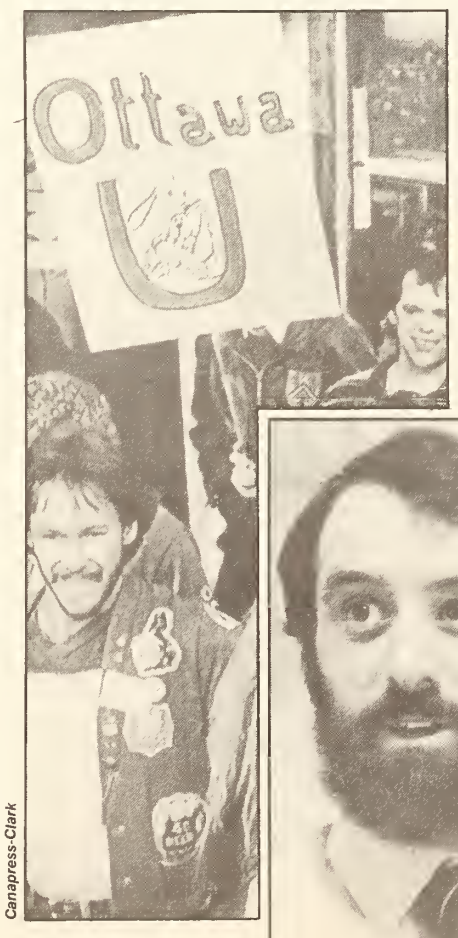
Says Dr Goodstadt: "Canada has got nothing, and we're doing nothing."

Both Dr Goodstadt and Ms Caleekal-John say lack of funds for programs and more comprehensive studies has put a stranglehold on any attempt to deal with the issue.

"Funding is the main issue," says Ms Caleekal-John, who is no longer with ARF.

Canapress-Clark

A rite of passage (above and left): alcohol use increases significantly at university



Canapress-Clark

Goodstadt (right): we're doing nothing

"Without money, you can't set up a program."

Dr Goodstadt agrees: "There is a real need for more, careful, systematic studies of campus drinking. The problem isn't doing the actual studies. The problem is financing. One would think that the provincial government would be interested in partly funding these studies because of their investment in the institutions and students.

"After all, students are a very important national, human resource. One would presume that the government would want to get something for its dollars and would want to invest in (solving) those things that are getting in the way."

Valerie Jacobsen, co-ordinator, program policy development and administration, ministry of Colleges and Universities, says alcohol education programs "are not eligible for any funding from this ministry." She says the ministry's policy of funding only credit courses "has been around as long as the ministry."

The Ontario ministry of Health is also unprepared to fund programs for students, says Gerry Conway, assistant director, information services, the ministry's Health Promotion and Information Branch.

"All the universities are interested in setting up programs," claims Ms Caleekal-John. "There's just no funding." She says a recent solicitation letter for contribution projects from the Health Promotion Directorate, Health and Welfare Canada, makes clear the federal government's position.

"They're willing to fund programs in the priority areas, such as children and youth, or women and addictions," she says, "but there's no way they are willing to fund university student programs because it is not considered a priority area."

Joan Johnston, program officer with the Health Promotion Directorate, confirms university students do not constitute a target group at present. "Obviously, we're looking at (helping) people in the most need, based on our experience of what people are most interested in and various data gathered from health studies." Ms Johnston says studies like the ARF survey of university students may lead to revised priorities, "perhaps in the future."

Neither Dr Goodstadt nor Ms Caleekal-John believes further studies and programs need be expensive. "I think we could get quite far on relatively little cost," says Dr Goodstadt. "The first thing would be to get faculty and students to give us more information. That doesn't have to pose an extraordinary cost."

Ms Caleekal-John estimates that a full-time campus alcohol education program could be structured for $12,000, excluding the program director's salary.

Dale Fogle, director of counselling services, Wilfrid Laurier University, says the school's BACCHUS program requires minimal funding. "Initially, funding arrangements were ad hoc," he says. "Now, BACCHUS receives a small budget allocation from university coffers. Some attention is also being paid to outside funding."

Mr Fogle says his school's program receives "a lot of logistical support" from BACCHUS' central office in Gainsville, Florida. "There is a lot of uniformity in BACCHUS programs, in terms of philosophy."

He explains BACCHUS is essentially a student-run program, a concept that lends itself well to the climate of austerity now pervading the educational system.

Says Dr Goodstadt: "One of the things that annoys me about universities . . . is that people are always looking for projects, and, often, there are projects right under their noses. If a professor is willing to take a program on part-time with some student help, that constitutes a lot of inexpensive labor right there." He says some universities are exploring joint studies, each of them shouldering part of the cost.

Regardless of funding structure or sources, ARF researchers say programs are badly needed: "Evidence of serious negative consequences of alcohol use among university students, affecting many domains of their lives, suggests that intervention is necessary as a preventive step in reducing or avoiding these consequences, both during a student's life at university and after leaving the university environment."

THE BACK PAGE

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The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

On state visits she shares anti-drug views

Nancy Reagan enlisting her peers

By Harvey McConnell

WASHINGTON — Information about the parents movement against drug use in the United States is being passed on to the wives of top officials in Zimbabwe and Portugal by Nancy Reagan.

Mrs Reagan, wife of the US president, revealed in a speech to the second annual conference of the National Federation of Parents for Drug-Free Youth (NFP) here that during recent state visits she had discussed the situation in the US with the wives of Prime Minister Robert Mugabe of Zimbabwe and President General Antonio dos Santos Ramalho Eanes of Portugal.

Mrs Mugabe told her that her sister's son had become involved with drugs but now seemed to be cured of the problem. Mrs Eanes said she had heard of Mrs Reagan's involvement with the parents movement and asked for more information.

"I am sending her all the information I can get so she can start to get something going in her country," Mrs Reagan added.

Mrs Reagan told the conference she is more convinced than ever "we are on the right track, and together we can beat the drug abuse problem." She added she is happy about "the dramatic growth of the parents group."

While figures from the US National Institute on Drug Abuse indicate a fall in the use of some drugs by young people, (**The Journal**, April) there is still far too much drug use today, Mrs Reagan said. She sees the movement as the "parents liberation movement, as it liberates parents from guilt, from helplessness, all the emotions parents feel when a child turns to drugs."

It was announced at the luncheon honoring Mrs Reagan that the NFP has established a Nancy Reagan Speakers Bureau. The bureau has a list of parents whose children have been involved with drugs and who are ready to address a range of related topics from neighborhood meetings to state legislative hearings.

"These parents are from all walks of life and are ready to share creditable, current information about marijuana, alcohol, and other mood-altering drugs," said Carla Lowe, a member of the bureau.

The speakers are ready to spend from one hour to three days in helping out, Ms Lowe added. The bureau will be operated through the NFP headquarters.

Reagan (l): helping leaders help parents help kids with information (above, an AD Council/NIDA poster)

US elderly reselling Rx drugs to live

By Harvey McConnell

WASHINGTON — Many elderly people in the United States are now so hard pressed for money they are selling legitimate prescriptions to street drug users.

Bonnie Wilford, senior research associate at the American Medical Association, said the problem is worse in areas with high concentrations of the elderly.

The elderly patients receive prescriptions for drugs that are justifiable on medical grounds, "but they feel they need the money they can make by reselling these drugs for street use more than they need the medication," she said here.

Many elderly people have trouble communicating with doctors, and tend also to see a number of doctors. Most doctors do not know all of the medications many of their elderly patients have prescribed for them.

Another source of prescription drugs for street use is people who are not drug abusers but are skillful at getting prescriptions from doctors.

Wayne Bohrer, chief of the state and industry unit of the US Drug Enforcement Administration (DEA), said too often doctors are conned into prescribing controlled substances because they believe the con-artist patients.

In Florida recently a man who lost a foot in a motorcycle accident made a small fortune before he

(See — Bogus — page 2)

Ottawa moving on blood tests for alcohol

By Mitchell Beer

OTTAWA — Blood tests for drivers unable or unwilling to submit to breath testing will be a major component of new legislation on impaired driving to be released by the federal department of justice late this fall.

Justice Minister Mark MacGuigan's announcement came amid accusations from some provincial governments that Ottawa was dragging its heels on the proposed Criminal Code amendments. Two provinces have passed their own laws to permit blood testing, and others are in the process of drafting legislation.

In Ottawa, Cabinet approval is the last step before actual legislation can be unveiled, probably this month or next.

MacGuigan

Don Piragoff, criminal law adviser in the justice department, said the provision for blood sampling, to be carried out by qualified medical personnel, has been in the planning stages since a busload of tourists was killed by an impaired driver in Saskatchewan several years ago.

"That's really what started the ball rolling," Mr Piragoff said. Legal experts had considered and rejected possible measures to tighten existing laws, "but given the change in political climate on the issue of impaired driving the question was raised again."

He said the law would consider doctors' concerns they might be held civilly or criminally responsible for touching a driver — literally "applying force to the body" — for reasons other than medical necessity.

Mr Piragoff was reticent to discuss other elements of the Criminal Code package before details are released in the House of Commons. In general terms, he said the government is looking at "the whole structure of penalties and offences" for impaired driving, bearing in mind that stiffer prison

(See — Provinces — page 2)

INSIDE

NEWS

Briefly . . .

Peer pressure

TORONTO — The Insurance Bureau of Canada will be using peer pressure in its three-year advertising and public relations campaign against impaired driving. The Toronto-based group is aiming its campaign not at the drinking driver, but at his friends, relatives, and co-workers. The strategy is built around the line: "What would you do if your friend intended to drive after having too much to drink?"

Sudan ousts alcohol

KHARTOUM — A return by the Sudan to strict observance of Islamic law, which prohibits strong drink, was marked by pouring approximately $5 million worth of liquor into the Nile. Sudanese President Jaafer Numeiri signalled the start of the September operation by emptying a can of beer into the water. He was followed by soldiers and police who hurled crates, bottles, and cans — collected from recently-closed bars and liquor stores — into the Nile. The penalty for anyone caught drinking alcohol in the Sudan is 40 lashes.

Non-smokers' holiday

WINNIPEG — Non-smokers may soon have a haven in this city if plans for a non-smokers motel go ahead. A Winnipeg woman travelling in Texas was so taken by the idea of a non-smokers inn she has decided to pursue the idea here. Only non-smokers would be hired to run the inn and guests violating the ban would have to pay a penalty.

Plethora of quit plans

TORONTO — There may be no surefire way to quit smoking, but there is a smorgasbord of techniques from which to choose. In a United States government study, researchers found 116 different quit-smoking methods, including various medical, commercial, psychological, and acupuncture techniques. An estimated 95% of the 33 million US smokers who have stopped since 1964 have done so on their own. But that means 1.65 million had outside help from any number of methods, says an article in *Medical World News*.

Shoot the messenger

LONDON — Drug abuse could be reduced if less publicity was given to it, a Hertfordshire pharmacist told the British Pharmaceutical Conference here. Colin Hitchings said the misuse of opiates had been recorded for centuries "but the practice did not receive the hysterical publicity which has promoted drug abuse in the last 25 years." He said he thought the situation would improve in future, if less publicity was given to the problem.

Ignorance of the law

EXETER, Eng — Re-introduction of licences for shops selling tobacco and posting of the law concerning sale of cigarettes to children may be ways of combatting a rise in smoking by young people, says one GP here. A survey of 38 shops in the area revealed 28 assistants misunderstood the prohibition on sale of tobacco to anyone less than 16 years and seven had no knowledge of the law.

Study probes moms' ability to cope

By Betty Lou Lee

OTTAWA — With more awareness of and interest in child abuse, more psychiatric advice is being sought about the advisability of some mothers taking their babies home from hospital.

They include alcohol or drug abusers, those who have previously abused children, the mentally ill, the retarded, or the emotionally disturbed.

Donna Stewart, MD, chief of the psychiatric consultation service at St Michael's Hospital in Toronto, reported on 56 such mothers at the annual meeting of the Canadian Psychiatric Association here.

For three of them, severe and current alcohol and/or drug abuse was the main concern, although misuse was part of the problems of some others.

Dr Stewart found that with a variety of treatments, supervision, and community and family back-up, all but two of the women could take their babies home. The Children's Aid Society took the child of one woman who had murdered a previous child, and one who lived in parks and the subway.

Stewart: one lived in subway

Follow-up for the hospital study ranged from two weeks to eight years, but averaged six months, and none of the children showed evidence of physical injury. Some of those lost early to hospital follow-up were still being supervised by agencies that could not share their data because of client confidentiality.

Dr Stewart said the psychiatric opinions were sought because nurses or doctors in the maternity ward, social agencies, relatives, or friends expressed concerns about the women's ability to cope with their babies.

Some women were kept longer than usual in the maternity ward, rooming-in with their babies so they could be observed for coping skills and taught techniques for caring for the child.

Others were treated at the psychiatric unit before discharge with the babies. That included one of the alcoholics, who was then referred to Alcoholics Anonymous. The other two were referred to addiction rehabilitation centres, and all were placed under mandatory supervision by the Children's Aid.

In an interview with **The Journal**, Dr Stewart said it was common to encounter the denial which is part of addiction. "They might say, 'It's not a problem anymore,' or "Who told you that?'

"To be fair, some alcoholic women and some drug abusers are quite good mothers, but it does put a burden on them. We're seeing the worst cases, who are actively preselected."

She noted that although some women protested verbally they were capable of managing, their actions were contradictory. When rooming-in was suggested to one such woman, she protested, "What are you trying to do, drive me crazy, being with him 24 hours a day?"

Dr Stewart says practically nothing has been written about identification and prevention of potential child abuse in the prenatal and post-partum period. One study in England of abused children showed in retrospect that there was usually something in the maternity ward notes predictive of the abuse.

They add millions to pension coffers

Smokers benefit economy

TORONTO — Canadians have overlooked one of the key economic 'benefits' of smoking, claims an associate professor at the University of Toronto's faculty of medicine.

Anthony Rebuck, MD, told a recent workshop on the cost of smoking that Canada saved an estimated $565 million in 1980 as a result of cancelled pension expenditures following "deaths caused by smoking-related diseases."

Dr Rebuck said studies have estimated health care costs associated with smoking topped $2.4 billion in 1980, or roughly 11.5% of the total cost of hospital care and physicians' services. However, he said the estimate of pension savings through smoking-related deaths shows smoking "is not all cost."

He attributed his figures to a study published in the *Canadian Medical Association Journal* (Nov 1, 1982). In their study, entitled Costs and 'Benefits' of Cigarette Smoking in Canada, authors Mary Thompson, PhD, and William Forbes, PhD, say promotion of pension payment savings on this basis "would certainly be a highly undesirable social aim and could not form part of any social policy."

Dr Thompson and Dr Forbes note that if those among their sample population who died from smoking-related diseases had survived, the increased pension payments "would be slightly offset by a small increase, about 105,000, in the number of people aged 20 to 64 years who paid taxes."

Alc, cig tax denied for Medicare

WASHINGTON — A special study group has rejected the idea of an increase in federal taxes on alcohol and cigarettes as a means of raising money for the ailing government Medicare trust fund (The Journal, Aug).

By a vote of 6 to 3, the special study group bowed to enormous pressure from the alcohol beverage and tobacco industries to turn down the idea.

The Medicare trust fund, which helps support the program for the elderly, is expected to run out of money by 1990 because of the continual rise in medical costs.

Bogus patients victimize doctors, pharmacists

(from page 1)

was caught. The man's wound had healed but about an inch of bone was exposed at the ankle.

Mr Bohrer said: "He was not an addict, he didn't use narcotics, but he got 17 doctors to prescribe before we identified him. The 17 doctors were dispensing to him because all he had to do was walk in and discuss his supposed problem.

"He went back every two weeks to each of these 17 doctors for four months before we were able to identify him and arrest him."

At each visit to each doctor he was prescribed between 22 and 28 tablets of hydromorphone (Dilaudid). On the street, he sold each tablet for $35.

A couple on welfare in Philadelphia were able to use three doctors to obtain medication for a variety of symptoms. Neither was a user, and the DEA estimated they netted about $90,000 a year from the prescribed drugs they sold to drug abusers.

Mr Bohrer said many doctors get involved in dispensing narcotics or controlled drugs for what they consider bona fide reasons. "I think there is a lot of victimization of doctors that is occurring without their really being aware of it."

Expert con artists have gone beyond forging a stolen prescription blank: they now take them to printers and get a number of copies run off. The fake prescription blank with the fake prescription and fake signature are often very good, "and a lot are getting by the pharmacists," Mr Bohrer added.

Delbert Konnor, voluntary compliance coordinator with the DEA, said one good way to stop victimization of doctors and pharmacists is for both to know their patients "and if the patient is not living in the area then they need to find more information. They should verify the name if need be, verify the address, and start asking for information about the family."

Some shrewd con artists try to ingratiate themselves in the community and with the doctors and pharmacists. The downfall for many is they become greedy and go to more and more doctors and more and more pharmacists.

Mr Konnor said if doctors and pharmacists have a solid relationship, victimization can be reduced substantially.

Ms Wilford, Mr Bohrer, and Mr Konner spoke at the annual meeting of the Alcohol and Drug Problems Association of North America.

Provinces in the lead

(from page 1)

sentences aren't always the best deterrent.

"A lot of the clamor for change from the public seems to be focussing on tougher sentencing for impaired driving," he said, but research is showing that such measures only work in the short term.

But "the important thing that has come across to the public is that if you want long-term change, you have to have attitudinal change, and that doesn't necessarily come from amending the law."

While the federal government moves toward legislative change, both Saskatchewan and British Columbia have passed new laws on impaired driving, both of which await formal proclamation.

John Weir, assistant to Saskatchewan Highways Minister James Garner, said legislation permitting the taking of body fluids from suspected impaired drivers includes a section protecting medical personnel from civil liability barring negligence.

The situation is less straightforward with criminal liability, but Mr Weir said Attorney-General Gary Lane has given "as much assurance as he can that his office would not proceed with any actions against the medical practitioner in carrying out this element of our legislation."

As for the constitutionality of a province legislating on a criminal matter, Mr Weir said, "the line my boss has been using is that he's been given assurances by the Attorney-General's constitutional lawyers that we're on safe ground. We know there will be a challenge, but we'll face that when we come to it."

If the federal government had moved faster, he said, "none of this would have been needed."

In Manitoba, the Attorney-General's department is studying whether the Saskatchewan legislation would stand up to a test of constitutionality.

NEWS

Many addicts have family alcoholism history

Cocaine OD deaths on increase

By Lynn Payer

NEW YORK — The number of deaths from cocaine overdose exceeded those from heroin overdose in San Francisco during the first six months of 1983, David Smith, MD, told the Health and Addictions Conference here.

"From a drug epidemiology point of view this is just unheard of," said Dr Smith, medical director of the Haight-Ashbury Free Medical Clinic in San Francisco. Cocaine overdose deaths increased 300% in San Francisco between 1980 and 1982, with another 50% increase in the first half of 1983. There have been as many cocaine deaths in the first six months of 1983 as in all of 1982, he said.

The majority of deaths occurred in those using cocaine intravenously or "freebasing," Dr Smith said, although a few occurred with intranasal use.

"You can kill yourself by snorting cocaine, but you've got to work at it a lot harder," he said.

Dr Smith said cocaine abusers constitute by far the largest increase in abusers seeking treatment. In most United States urban areas the major treatment system for substance abuse is the alcoholism system, he said, pointing out that it requires little adaptation to treat cocaine abusers.

"If you understand alcoholism theory and practice, you understand 95% of what you need to know about cocaine. All you have to do is to brush up on toxicity, on what freebasing is, on sociocultural variables."

Of 100 people who use cocaine, 30% will become abusers and 10% addicted. Of the 10% who become addicted "70% have a family history of alcoholism," Dr Smith said.

The major reason cocaine users relapse, he said, is that they try to turn to controlled use. He reproached AA (Alcoholics Anonymous) groups that turn their backs on alcoholics who are also addicted to cocaine.

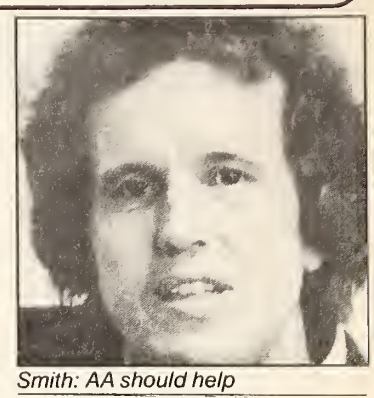
One of the reasons given, he said, is that the founders of AA designated the group must deal only with alcoholism. In reality, he said, the two founders were both cross-addicted and had said AA would work for any addictive disease. The restrictions about treating other substance abusers came in the second, third, and fourth generations, he said.

Dr Smith also talked about abuse of benzodiazepines, and he emphasized that doctors should make a greater effort to separate the "susceptibles" from the "non-susceptibles" before prescribing long-term benzodiazepine therapy.

"The majority of people have no problem with Valium (diazepam)," he said. "The two most important questions a physician should ask prior to prescribing a long-term course of benzodiazepines are: 'Do you have a family history of alcoholism?' and 'Do you have a past history of alcoholism?' If the answer to both questions is 'no,' the therapeutic ratio of long-term diazepam therapy would be much greater.

"If there is a past history of alcohol abuse, the therapeutic ratio for long-term benzodiazepine therapy is very narrow, and you'd better have a very good reason for prescribing it.

"Many physicians think that alcoholism is a Valium-deficiency disease," he said, noting that what often happens after a prescription of Valium for alcoholism is that the patient starts drinking again in addition to taking Valium.



Smith: AA should help

But Dr Smith also criticized programs that under-medicate withdrawal, or fail to medicate appropriately underlying psychopathology that is responsive to psychotropic medication.

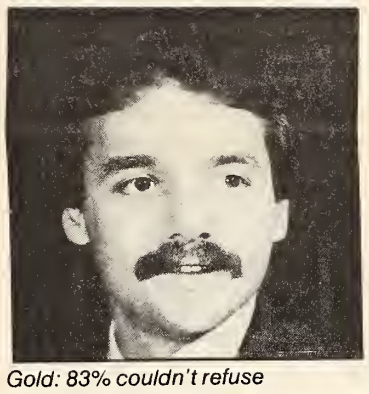
Users rank cocaine ahead of food and family

By Lynn Payer

NEW YORK — A random sample of the first 50,000 callers to 800-COCAINE — a toll-free telephone number for cocaine information — has shown a high level of perceived addiction and suffering, although most callers were still working, Mark Gold, MD, told the Health and Addictions Conference here.

Dr Gold, director of research for Fair Oaks Hospital in Summit, New Jersey, said the survey results suggest "we cannot conclude that even moderate intranasal use is without risk.

"The belief that cocaine is non-addictive, that it's somehow a social drug with low abuse potential, especially if used intranasally, is challenged by these findings that all three routes of administration are associated with compulsive abuse patterns."



Gold: 83% couldn't refuse

The 800-COCAINE number was begun May 6, 1983, superseding a local and now discontinued New York Cocaine Helpline (**The Journal**, July). In exchange for information and referrals provided to the callers, trained interviewers question callers for 25 to 30 minutes. The information obtained from such interviews, Dr Gold said, can help to fill the void between laboratory studies, which usually deal with first cocaine use, and autopsy and hospital studies, which deal with last cocaine use.

Of the random sample of 500 chosen from the first 50,000 calls, 61% snorted cocaine, 21% freebased, and 18% injected intravenously.

Although fewer than half the callers were daily cocaine users, 66% believed they were addicted to the drug, with 57% reporting withdrawal symptoms. Sixty-seven per cent reported being unable to abstain for one month, with 83% saying they could not refuse cocaine.

Cost far outweighed discipline in limiting drug use, Dr Gold reported, with 53% of intranasal, 77% of intravenous, and 79% of freebasers citing cost as the limiting factor. Discipline was cited by 25% of intranasal, 12% of intravenous, and 5% of freebasers as a limiting factor.

Of the callers 71% preferred cocaine to food, 64% to friends, 72% to family, and 76% to recreation. Fifty per cent preferred it to sex.

"We did a consumer survey where we asked these consumers whether they would spend money on movies, records, food, fast food, going out to eat, going out with friends, cocaine, other drugs — there is a list of 10 things. Nine of 10 cocaine users said cocaine, with the other 10% spread out over all those other things."

Dr Gold said 67% of the callers were male, which should be interpreted considering that most men don't ask for help or call crisis services.

"Is it a male disease, or just a working disease?" Dr Gold asked. Seventy-six per cent were employed outside the house and most of the others worked at home, with 40% making more than $25,000 a year. The average cost of a week's supply of cocaine was $637, ranging from $100 to $3,200 a week.

Twenty-five per cent reported loss of job, 26% loss of spouse, 51% loss of friends, and 42% loss of all money. Sixty-six per cent had been in fights and violent arguments because of cocaine, and 27% had been faced with a threat of separation or divorce. Of the callers, 39% had had auto accidents because of cocaine, 39% were dealing cocaine, 29% were stealing, and 12% had been arrested.

"You have a lot of effects on non-users," Dr Gold said.

Psychologic suffering included depression and anxiety in 83%, with 10% of callers having attempted suicide. Irritation was reported in 82%, lack of motivation in 66%, paranoia in 65%, and difficulty concentrating in 65%. Loss of memory was a particular problem for those working on Wall Street, Dr Gold reported.

Chronic sleep problems were experienced by 82%, chronic fatigue by 76%, severe headaches 60%, runny nose 60%, and cough and sore throat 46%. Seizures were reported mostly by intranasal users and freebasers.

Bottomsworthy enters the board game game

By Wayne Howell

The great depression spawned Monopoly, the grand-daddy of all board games. The recent economic recession has spawned a few noteworthy board games as well. A New Zealander is now a millionaire as a result of a Monopoly-like game which has swept Australia and Europe and is soon to appear on American shores. Two Canadians have pursued and won a lifetime of financial security as a result of a game called Trivial Pursuit. And, not to be outdone, two unemployed Montrealers plan to alter their status in a dramatic way by marketing an unemployment game.

All this activity has not been lost on my friend Dr Bottomsworthy, whose main regret in life is that his salary as a tenured professor does not provide the style of life to which he would like to be accustomed. And so he has invented a board game of his own called Options.

The professor's game gives everyone the chance to be a Czar of social policy. The board is similar to a Monopoly board except that instead of landing on squares labelled Boardwalk and Park Place you land on squares labelled Hard Drugs, Alcohol, Gambling, etc. When you land on one of those squares you have to formulate a policy.

The two basic policy choices are *Police*, in which case you make the activity illegal, and *Price*, in which case you regulate it and take a piece of the action. *Pricing* allows you to collect *Tax$$Cards* every time you pass *Go*, but you also have to pay *Social$$Costs* at the same time. *Policing* gives you no *Tax$$Cards* when you pass *Go*, but in certain circumstances it keeps the *Social$$Costs* to a minimum.

Professor Bottomsworthy has built in a mind-boggling number of correlations between *Policing*, *Pricing*, *Tax$$Cards*, and *Social$$Costs*. In some cases, a player can find himself up against a mysterious third party known as *Underground* that accumulates untaxed revenues, runs them through "the laundry," and then uses them to wrest control of the game from you.

You win the game if you choose policies that result in a net gain for your treasury. If you don't make the right choices, then your *Social$$Costs* cards pile up, cancelling out your *Tax$$Cards* and you are out of the game.

It is impossible to summarize the rules of Professor Bottomsworthy's game in a paragraph — like the rules of all good board games, they are arcane and complicated. The important question is, how is this game going to fare in the marketplace? Will it, as Professor Bottomsworthy confidently assures me, allow him to realize his dream of owning an ocean-front villa in the Bahamian out-islands and a 35-foot ketch? To find out, I interviewed some of the people who had actually played the professor's mock-up version:

Randy (age 15): Yea, it's okay I guess. I was doing real fine *Pricing* prostitution for awhile, while the rest of the players were *Policing* it like crazy. But when the long-term *Social$$Costs* started to come in I went belly-up. Yea, I'd like to try it again. Maybe.

Beth (age 18): It's a dumb game. Like I *Policed* everything right from the start: no boozing, no drugs, no gambling, no whoring. I figure so what if I'm not getting any *Tax$$Cards*, I wasn't getting all those *Social$$Costs* cards like Bill and Mindy. Big deal — I got taken over by the *Underground*. I don't think that money-laundry thing is fair. Like I said, it's a dumb game.

Mindy (age 15): Bill was smart when he went into *Pricing* gambling in a big way. He got good *Tax$$Cards* every time he passed *Go* and the *Social$$Costs* were real low. He got to be a pain actually. Every time he passed *Go* he would squeal 'It's such fun' like that stupid woman in the Lottario television ad. I thought I was going to win by *Pricing* soft-drugs, but I guess I didn't read the rules carefully enough, because there were big *Social$$Costs* that came in late in the game and they wiped me out.

Bill (age 17): It's not a bad game I guess. I lasted the longest so I guess you could say I won. I did okay *Pricing* gambling, but it's always alcohol that gets you in the end. You *Police* it and the *Underground* eventually takes over. And no matter how you *Price* it you seem to come out a loser whenever you pass *Go*. Like I started out *Pricing* it low and I ended up with measly little *Tax$$Cards* and huge *Social$$Costs*. So next time I landed on the alcohol square I *Priced* it high and that varied the ratio a bit, but I still didn't come out ahead because the *Underground* started to move in on me. But some people *Priced* it moderately and they still didn't come out any better.

Arthur (age 20): I agree with Bill. It's not a bad game, but it seems like it's rigged against you; things just keep piling up and those damn *Social$$Costs* eventually do you in, whether you *Police* like Stalin or *Price* like a discount store. At least with Pac-Man you get to clear the board now and then. I prefer Pac-Man.

As can be seen, the reviews were decidedly mixed. I reported to Professor Bottomsworthy that he had indeed invented something, but it did not appear to be a game that people enjoyed playing.

"What if I adapted it for laser-disc video?" he said, ever the optimist, "we get some good high-resolution color graphics, some snappy sound effects, and it will take the arcades by storm."

"I don't think you've invented a game at all," I said. But he didn't hear me; he was hunched over his Commodore 64 color computer, visions of the Bahamian out-islands dancing in his head.

NEWS

RESEARCH UPDATE

Zimelidine may reverse memory impairment

Work with a drug that affects the body's neurotransmitter system may shed new light on the mechanism by which alcohol intake impairs memory. Using zimelidine, a relatively specific blocker of serotonin reuptake, researchers from the United States National Institute of Mental Health, the US National Institute on Alcohol Abuse and Alcoholism, and the department of psychiatry, University of California, Irvine, studied 10 male volunteers given varying levels of ethanol. Zimelidine (**The Journal**, April, Dec 82) reversed the memory impairment in 80% of subjects given a high dose. The researchers hypothesized zimelidine may weaken the effects of alcohol on memory and learning "either directly by stimulating serotonergic activity or indirectly through secondary effects on noradrenergic functions." They concluded the interaction between zimeldine and ethanol "may suggest new strategies for reversing state-dependent effects of ethanol on mental functions."
Science, July 29, 1983, v.221:472-473

Diazepam's benefits and drawbacks

Treatment of a group of chronically anxious patients with diazepam has shown both the benefits and drawbacks of using benzodiazepines. The double-blind study by the department of psychiatry, psychopharmacology research and treatment unit, University of Pennsylvania, involved treating 180 out-patients with from 15 mg to 40 mg/day of diazepam continuously for six to 22 weeks. The findings indicated a significant number of patients benefited from the treatment, and tolerance to the anxiolytic effect of the drug did not develop during the study period. Withdrawal reactions were linked to the duration of treatment with sedative-benzodiazepines; patients treated with these drugs for less than eight months had withdrawal incidence of 5%, while 43% of those treated continuously for a longer period had clear withdrawal reactions. "Clearly, the longer the treatment, the greater the likelihood that a patient may become physically dependent on therapeutic doses of benzodiazepines," the study said. The researchers concluded that gradually discontinuing treatment should contribute to reducing the risk of dependence.
Journal of the American Medical Association, Aug 12, 1983, v.250:767-771

Age at first drink

The age at which young men have their first alcoholic drink has been linked with subsequent alcohol- and drug-related problems and some psychiatric problems. The survey of 1,012 university students or non-academic staff aged 21 to 25 years at the University of California, San Diego, was conducted by Marc Schuckit, MD, and Jon Russell, PhD. Using the self-reported age at first drink, the researchers found a quarter of the study group reported being 13 years old or younger when they had their first drink, and 29% were age 17 or older. The incidence of alcohol-related problems consistently decreased with increasing age at onset of drinking as did the percentage of subjects reporting drug use or drug-related problems. These problems are not necessarily diagnostic of alcoholism, the researchers said, because a number of young men report such problems but grow out of them by permanently moderating their drinking. The study concluded age of first drink "is a useful clue for counsellors and other clinicians in attempting to identify university subpopulations at elevated risk for substance-related and emotional problems."
American Journal of Psychiatry, September, 1983, v.140:1221-1223

Smoking and retinopathy unrelated

There is no evidence to link cigarette smoking with diabetic retinopathy, indicates an examination of diabetics in southwestern Wisconsin. This non-inflammatory disease of the retina is common among diabetics, and an association with smoking had been hypothesized by some authors because of other observed effects of smoking on the body. The study by Ronald Klein, Barbara Klein, and Matthew Davis of the department of opthalmology, Wisconsin Medical School, examined 2,990 diabetics of varying ages with diabetes of varying duration. The prevalence of retinopathy in the subjects increased with the increasing duration of diabetes, reaching 97% in those under 30 years of age with diabetes of 15 years duration or more. After testing 55% of the study population, the researchers concluded "no association was found between cigarette smoking and diabetic retinopathy . . . The lack of a dose-response relationship of smoking and retinopathy is convincing evidence that such a relationship does not exist."
Journal of Epidemiology, August, 1983, v.118:228-238

Stable social drinking for some

A long-term follow-up of a group of British alcoholics indicates some found it possible to return to stable social drinking. Research at the Addiction Research Unit of the Institute of Psychiatry, London, looked at 99 married men treated for alcoholism between 1968 and 1970. More than a decade later, 18 of these patients had died, a mortality rate two-and-a-half times that of the general population. Of those still surviving, 68 were interviewed to obtain information on drinking habits and lifestyle. In this group, 47% were still drinking in an uncontrolled fashion, and 43% had ended their marriage in divorce or separation during the follow-up period. More optimistically, eight subjects who had initially not been severely dependent had returned to a stable pattern of social drinking. The researchers concluded such a long-term follow-up can provide valuable information.
The Lancet, July 30, 1983, no:8344:269-271

Pat Rich

Moderate drinking possible for some alcoholics: study

By Betty Lou Lee

OTTAWA — Long-term follow-up of severe alcoholics in the Gaspé area of Quebec shows about 9% have returned to moderate drinking without signs of dependence. Thirty-five per cent were abstinent.

The 150 men were followed from one to 12 years, with a mean of six years. Their mean age was 48 years, and they had been alcoholic for an average of 17 years. They lived in an economically depressed area and were of low socioeconomic status.

All were treated for three weeks at a rehabilitation centre in Ste Anne des Monts.

Maurice Dongier, PhD, chairman of the department of psychiatry at McGill University in Montreal, who presented results at the annual meeting of the Canadian Psychiatric Association here, said abstinence was the only goal during the treatment period. Attendance at Alcoholics Anonymous (AA) was mandatory.

"To none of the patients was any form of controlled drinking suggested.

"Clearly, alcohol dependence is far from being a constantly progressive disease, as a number of alcoholics are able to resume normal consumption; the belief that a drink triggers in an alcoholic an uncontrollable need to drink more is not empirically verified," he noted.

But since it isn't possible to predict which patients will be able to return to controlled drinking, and which can't, "it is safer to continue to advocate abstinence as the only goal of most subjects."

About two-thirds of the men showed some improvement. In addition to those abstinent or drinking moderately, 23% were judged to be alcoholics of average severity. The patients' reports of consumption were checked with wives, relatives, or others in 69% of cases, and in only 7% of these were there more than minimal discrepancies, which Dr Dongier found surprising.

Other findings were that those who followed the AA program regularly after discharge "were more often abstinent but did not improve significantly in most psychosocial indices."

Abstinence didn't significantly relate to a change in socioeconomic, employment, or family status. But there was an improvement in legal status, psychopathology, community activities, hardship for families, and behavior at work and in the community.

"Compared to moderate drinking, abstinence is therefore an obvious factor in a good psychosocial prognosis," Dr Dongier said.

He said psychiatrists in general have a negative attitude to alcoholics, often viewing them as unreliable, unrewarding, and non-compliant.

"This is in contrast with the literature, which seems to escape the attention of most psychiatrists and physicians."

The literature indicates a better prognosis for the treated alcoholic than is generally believed, he said. There are also interesting developments in the biology of predisposition to alcohol abuse, which should make it a continuing interest of medicine, as well as the social sciences.

Alcohol programs are extremely complex

Treatment comparisons are risky

By Harvey McConnell

WASHINGTON — Trying to compare treatment programs for alcoholics to determine which is "best" can cause enormous problems and hostility, says Barbara McCready, PhD, of the Center of Alcohol Studies at Rutgers University.

On the one hand, some treatment issues seem clear cut — for example, which drugs are most effective in treatment of withdrawal and the fact involvement of the family in treatment leads to better outcome, said Dr McCready, newly-appointed clinical director of the New Brunswick, NJ, centre.

On the other hand, she told the annual conference of the Alcohol and Drug Problems Association of North America here, trying to find out which is the best treatment program "results in pitting treatments against each other in a way which produces competition and territoriality.

"So, trying to say what treatment is 'best' almost means one treatment is going to be worst, and whichever treatment program comes out worst in a study means people in it are never going to want to be involved in research again."

Another problem is that most treatment programs are extremely complex and have many different active elements. And while programs seem different in many ways, some techniques are similar; many of the elements in the Alcoholics Anonymous program and programs of behavior therapy are almost identical.

Dr McCready said that in the coming decade researchers will be trying to find out which choices will achieve the same treatment goals, and which are the most effective.

Effort is now being given to looking at the components of situations and acquisition of skills that can assist people to stay sober.

"Another question is, can we find subgroups, look at their characteristics, and then match with treatment?" Dr McCready said this involves such things as alcohol dependence versus alcohol abuse, advice versus treatment, affective disorders and depression.

Recent research has shown that cognitive functioning recovery is slow in many older and long-time alcoholics. Treatment programs need to focus on the best way to work with such people.

Another question to be answered is how to help a person maintain gains made in treatment.

Finally, Dr McCready said, "evaluation should be done by someone who is neutral and not by someone who is passionately committed to one outcome."

Employees may cover for an alcoholic boss

TORONTO — Executives and professionals who abuse alcohol are often protected by subordinates who have a "vested interest" in seeing that the boss doesn't get help, claims the president of a Washington, DC, treatment facility.

Donald Phillips, president of Cope Inc says the power wielded by top managers and professionals allows them to "reward people working for them and people close to them. As a result, I've seen incredible degrees of subordinates' covering up for their bosses. There seems to be a vested interest."

At the same time, "many executives have an incredible knack for intimidation, particularly as the degree of impairment increases. They even intimidate their superiors," Mr Phillips told Input '83 here, the 5th Biennial Canadian Conference on Employee Assistance Programs.

Mr Phillips outlined one case involving a senior executive who reported directly to the company president, with whom he had developed a close friendship.

The senior executive "was brilliant. He pulled off some major accomplishments for the organization. But he had the most negative impact within that organization of any person I've ever seen." He so effectively intimidated his peers and subordinates that help was not directed by the company president until a crisis occurred, he said.

Mr Phillips said the "strong sense of fraternity at the top," the autonomy and freedom of movement senior staff members usually enjoy, and denial of the problem "because of their accomplishments," are also obstacles preventing such people from getting the help they need.

NIDA plans EAP study

WASHINGTON — The United States National Institute on Drug Abuse (NIDA) plans in financial year 1984 to study a sample of employee assistance programs (EAPs) to assess the type and extent of the drug abuse problem in industry.

Dorynne Czechowicz, MD, assistant director for medical affairs at the NIDA division of prevention and communications said the study will look at the number and types of clients served, program structures, types of intervention approaches, outreach techniques, efficacy of treatment approaches, and cost effectiveness.

The study will also try to determine the extent to which specific drug abuse treatment services are provided to employees, and identify needs for technical assistance. The focus will be on both prevention and treatment within the EAPs.

Workers demanding to be protected from drug-using colleagues

By Harvey McConnell

WASHINGTON — A groundswell among blue-collar workers demanding that management come to grips with drug abuse in the workplace is being detected by officials at the United States National Institute on Drug Abuse (NIDA).

Michael Walsh, PhD, chief of the behavioral pharmacology branch at the NIDA, said a number of calls are being received from companies and public agencies.

"I get the sense that for a long time these folks have been accepting a situation they felt was unsafe and they didn't care for," he told the annual conference of the Alcohol and Drug Problems Association of North America here.

In Washington, for example, Dr Walsh said, "I hear the bus and subway drivers, supervisory personnel, and security and maintenance people are saying: 'Listen, there are enough people in the city of Washington who are unemployed and can do these jobs. We want you to begin to get these people (drug users) out of it because they cause accidents.' "

Dr Walsh said a major problem is ascertaining the nature of drug abuse in the workplace "primarily because of the illegal nature of drug use, and primarily because in large companies if somebody is found using or selling drugs in the workplace they get fired. It is quick and easy."

More and more companies and city and state agencies are screening applicants for jobs and not hiring those with traces of drug use.

Dr Walsh added: "The use of drug-detecting techniques, ranging from urine screening to drug-sniffing dogs, is a very, very complex area for industry to get into. Because of the political issues and the labor issues it has been very difficult for companies to begin to get involved.

"But some companies have developed policies and come out of the closet, so to speak, and made public what these policies are."

The groundswell for action by blue-collar workers puts the labor unions in a ticklish position because many expressed real resistance at first to drug use screening.

Companies who instigate screening programs also need good technical assistance. While screening can act as both a prevention and treatment tool it must be carefully approached.

Dr Walsh said the NIDA recommends action not be taken on the result of a single screen. Confirmation should be sought from another laboratory, or another assay used. Screening should just be part of a program: "We don't just want to stamp out drug abuse and create more alcoholics than there already are."

Steve Gardner, DSW, of the NIDA's prevention branch, said the agency had assisted the fledgling US Football League in establishing a program to help players cope not only with drug use, but also with the pressure of big-time sport, and with ways to live life after football.

Dr Gardner said a company needs to spell out what behavior is acceptable and what is not. Another issue is whether the aim is to stop all drug use, or to do something about use which impairs the worker and lowers productivity.

An ideal program would focus on wellness, with drug use as part of the program, Dr Gardner said.

Companies also have to face the problem of drugs in the workplace "versus (the question) how can you give one message in the place of employment when there is another message in society and the media, and it is largely that drugs are okay, and that a lot of people can do them and won't be hurt."

Unions: a ticklish position

While there is a lot of awareness of the problems, "I don't think things have happened as fast as they should have," Dr Gardner said.

Commenting later to **The Journal**, Dr Walsh said: "The crux of the problem is walking the fine line between individual rights and public rights."

Society expects those in certain occupations, such as bus drivers, airline pilots, nurses, or surgeons, to exercise public rights. In fact, rights extend into day-to-day dealings.

Dr Walsh: "If you take your car to a dealer to get the brakes fixed, you assume the guy is going to do the job right, and you have no right to assume otherwise."

Management must take a firm line in certain occupations. As for drug use by management, it may become similar to the US Navy; an enlisted man is allowed one "dirty" urine and a chance of rehabilitation, an officer is immediately discharged if he ever has a "dirty" urine.

Another problem to be faced down the line: "If a person in a security sensitive, or safety sensitive, position is identified and referred to treatment, can that person be placed in his or her old job again?"

GILBERT

'. . . two extraordinary changes in caffeine-beverage use . . . have been happening in the US'

Caffeine consumption

By Richard Gilbert

My last column about caffeine consumption appeared in August 1980. There I noted Canada had passed the United States in per capita caffeine use during the 1970s and would be passing the US in per capita coffee use, if current trends continued, in the 1980s. I also sketched the tumults in world coffee and tea consumption that followed the massive frosts in Brazil in 1975.

Recently, I completed an analysis of global caffeine consumption for a book to be published next year (*The Methylxanthines*, G. A. Spiller [ed], New York: Liss). This analysis refines, in light of more recent data, some of the observations I made here three years ago. It provides some focus on two extraordinary changes in caffeine-beverage use that have been happening in the US. One is an astonishing decline in coffee use by young people. The other is a remarkable increase in soft drink use.

Global picture

The global picture is given in the upper part of the table on the right. World caffeine use of about 120,000 tonnes a year, or 70 milligrams a day, means that the average human consumes each day the caffeine equivalent of a largish cup of instant coffee or a smallish cup of drip-made coffee. Caffeine derived from coffee comprises 54% of all caffeine use; caffeine from tea accounts for 43%. These proportions include the caffeine in soft drinks, nearly all of which is a by-product of the manufacture of decaffeinated coffee or tea. "Other" in the table includes the caffeine in cocoa and chocolate (1,350 tonnes), in yerba maté or Paraguayan tea (1,250 tonnes), and in kola nuts, yaupon leaves and berries, guarana seeds, and the bark of the yoco tree.

North Americans consume caffeine at three times the world rate — the equivalent on average of two to four cups of coffee a day, depending on the size of the cup and the method of preparation. In this part of the table, the caffeine consumed in soft drinks is given separately. It accounts for some 17% of caffeine use in the US and 7% in Canada. I have not been able to find data on the use of caffeine in soft drinks elsewhere, but I guess that caffeine consumption from this source is usually much lower.

Also shown in the table are caffeine use by a heavy coffee-using country, Sweden, and by a heavy tea-using country, the United Kingdom. In both cases, consumption is twice the North American rate. Here soft drinks are included among "other" sources. Neither Sweden nor the UK tops its respective league, according to the latest figures. Finland is the country where most coffee is consumed per capita (the equivalent of 355 mg caffeine per day), and the Persian Gulf state of Qatar is where most tea appears to be consumed. Each of Qatar's 100,000 inhabitants uses the equivalent of 665 mg caffeine from tea each day, on average.

Hazardous use

In 1976, I suggested the threshold of hazardous caffeine use for healthy, non-pregnant adults is probably 600 mg a day, a level that has been adopted by a number of authorities. It is roughly equivalent to the caffeine in eight average cups of coffee or about twice that number of cups of tea. Chronic use of caffeine at rates below 600 mg a day can result in physical dependence on the drug, but it is unlikely to be harmful. Chronic consumption of more than 600 mg per day might make the user susceptible to heart conditions, cancer, stomach ulceration, insomnia, and persistent anxiety. It seems the average inhabitant of Qatar could be vulnerable to these ailments. A study of caffeine use in some native Indian communities around the James Bay in Canada in the 1970s found average caffeine use among adults of nearly 1,000 mg a day, mostly from tea.

Remarkable things have happened to consumption of caffeine-containing beverages in the US during the past two decades. Since 1960, coffee use has declined by 36%, tea use has increased by 33%, and soft-drink use has increased by an astonishing 231%. (During this period more than 80% of all soft drinks sold in the US contained caffeine, averaging about 35 mg per 12-ounce serving.) The net result of these changes has been a decline in caffeine use of about 20%.

Close examination of US coffee-drinking patterns reveals an almost perfect, negative correlation between age and change in coffee use during the past two decades. Consumption among 15 to 19, 20 to 24, and 25 to 29 year olds has declined by 70%, 69%, and 55% respectively, while consumption among older people has declined much less. In 1962, coffee use by 20 to 24 year olds was 98% of the national average, but only 48% in 1982; whereas use by 60 to 69 year olds was 96% of the national average in 1962 and 139% of the national average in 1982. Coffee has become a drink for older people, at least in the US.

Another way of viewing this massive decline in US coffee use is to note that 75% of the population aged 10 years and more drank coffee regularly in 1962, but only 56% did so in 1982. Cups consumed per drinker declined much less: to 3.4 per day in 1982 from 4.2 per day in 1962. Another point to note is that much of the fall in coffee use took place in the 1960s, before concerns about caffeine's effects on health became newsworthy.

Caffeine source	Total caffeine consumption (tonnes)	Per capita consumption (mg/day)
World:		
Coffee	64,500	38
Tea	51,500	30
Other	4,000	2
Total	120,000	70
United States:		
Coffee	10,300	125
Tea	2,850	35
Soft drinks	2,850	35
Other	1,300	16
Total	17,300	211
Canada:		
Coffee	1,200	128
Tea	700	79
Soft drinks	150	16
Other	150	15
Total	2,200	238
Sweden:		
Coffee	1,300	340
Tea	100	34
Other	150	51
Total	1,550	425
United Kingdom:		
Coffee	1,700	84
Tea	6,500	320
Other	800	40
Total	9,000	444

Precise data on who uses soft drinks are not available, but it is reasonable to suppose that the massive increase in pop consumption has been mostly among young people and, consequently, that this "explains" the fall in coffee use among the same age groups. The explanation merely begs the question as to why such a shift from coffee to soft drinks should occur.

Different story

The story in Canada has been different. Considering the broad similarity of the two countries as consumer markets, this makes the US trends even more surprising. The changes in consumption in Canada have been relatively slight: since the early 1960s coffee use has increased by about 10%, tea consumption has declined by about 20%, and soft-drink use has gone up by 66% — a large increase but very much below the one in the US. Soft drinks aside, a neat way to summarize the changes is to say that in caffeine-beverage use the US is becoming like Canada. Usually things happen the other way around.

The remarkable divergence in soft-drink use is a fascinating phenomenon. In the early 1960s annual consumption in both the US and Canada was between 40 litres and 45 litres. Now it is 150 litres a year in the US and 70 litres in Canada. If we could get a better handle on what has caused this divergence (advertising, availability, price, climate, falling coffee use?) we would probably know very much more than we do about the causes of all kinds of beverage consumption.

If you would like a copy of the manuscript of my book chapter, please write me care of The Journal, Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1.

NEWS

Anti-drink ad glamorized sex

NZ alcohol group caught in its own restrictions

By Pat McCarthy

AUCKLAND — Should sex be used to promote sobriety? Confronted with this dilemma, New Zealand's Alcoholic Liquor Advisory Council has neatly turned a row over a sexual proposition into a storm in a tea cup.

The council's dilemma was over a television advertisement it sponsored. The commercial became the focus of a national controversy.

Designed to promote moderation among young male drinkers, the commercial featured a drunk young man propping himself up at a party while his young woman friend exhorted him to stop drinking and turn his attentions to her.

What caused the controversy was the song she belted out: "Stop making love to that bottle, baby, and start making love to me."

Criticism of the commercial — claiming it glamorized premarital sex — mounted from politicians, newspaper publishers and advertising firms, the liquor industry, and the public. "Trying to get youngsters off the hops by encouraging them to sow wild oats is outrageous," declared one letter-writer to a daily paper.

In August, 10 months after it began screening, the commercial was ordered off television by council chairman John Robertson, because it used sex and permissiveness to make its point.

He said the council had recently supported the removal of television advertising by two liquor outlets — one featuring British comedian Benny Hill in a routine loaded with sexual innuendo — "on the grounds that it was in shocking bad taste and likely to unduly influence the young on alcohol consumption" (**The Journal**, Oct).

Mr Robertson, a former Secretary of Justice, added: "I personally cannot further tolerate the position where on behalf of the council I have to preach a set of standards for public advertising and ignore these standards in our own advertising because we consider the end justifies the means."

Members of the council's education and information committee publicly challenged Mr Robertson's decision. Sally Casswell, director of Auckland University's alcohol research unit, which had been involved in developing the commercial, said market research showed that its message — that it is unattractive to be drunk — had been "going over extremely well" with men between 20 and 30 years.

Minister of Health A. G. Malcolm, a former advertising executive, also entered the controversy, saying: "I thought it was a jolly good ad, and I was very disappointed to see it withdrawn."

Meeting to consider the commercial's fate, the council opted to retain it but in a revised form.

Now the woman hangs on to her virtue and sings: "Stop making love to that bottle, baby, and go and make a cup to tea."

"It is deliberately corny and humorous," says Dr Casswell. "But the message is still there."

France lowers BAL

PARIS — A bill to tighten up France's drunk driving laws has been approved by the French cabinet, and a breath-test developed in West Germany is to be introduced. A government spokesman said under the new law the permitted blood alcohol level will be lowered from 0.15% to 0.08%.

Reformulated Talwin discouraging Ts and Blues abuse: manufacturer

WASHINGTON — Drug abusers are trying a number of methods — so far without success — to remove the narcotic antagonist naloxone from the "T" of Ts and Blues.

The combination of Talwin (pentazocine) and Pyribenzamine (tripelennamine) has been used by many heroin addicts and other drug abusers.

In an effort to stop Talwin abuse, Winthrop Laboratories, the manufacturer, received permission from the US Food and Drug Administration to add 0.5 mg of naloxone to the formulation. The naloxone does not affect patients who take the drug orally as prescribed.

However, when Talwin is ground up with Pyribenzamine and injected intravenously the naloxone blocks the receptor site and the user gets no high. The naloxone, in fact, could cause withdrawal symptoms.

Sol Rubino, manager of professional services for Winthrop, told the annual conference here of the Alcohol and Drug Problems Association of North America that their scientists have tried 13 different processes to separate the naloxone from the reformulated Talwin.

The same thing is being tried by drug abusers, it has been reported; some have even tried to boil off the naloxone. However, the abusers have been as unsuccessful as the scientists, said Mr Rubino.

He said when the reformulated Talwin was put on the market in February, 25,000 posters were distributed warning abusers they could suffer severe withdrawal.

Mr Rubino said the reformulated Talwin has proven effective for legitimate clinical use, and no abuse of the new compound has been reported.

He added: "No manufacturing company wants to get involved with a drug that has an addiction problem. Nothing can impact so negatively with the kind of publicity some of us have had to endure."

If you are a "T's and Blues" user, you are in for a surprise. The chemicals in the mixture have been changed. A drug called naloxone has been added to Talwin® 50© tablets. It is now called Talwin® *Nx*©. It is harmless to patients who take the tablets under a doctor's orders. But it can get you into serious trouble if you mix it into T's and Blues.

It won't get you high.

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So remember: new Talwin *Nx* is a pale yellow, oblong tablet with the marking "T-51." Don't mix it into T's and Blues. It can hurt you.

Warning: Ts and Blues users told of dangers

Female monkey model will advance research on alcoholic women

By Harvey McConnell

WASHINGTON — Non-invasive body scanning, molecular biology, and monkeys will help advance research into alcohol and other drug problems in this decade.

While research opportunities are widening, some basic questions are still unanswered, says Lois Chatham, PhD, acting director, division of extramural research, United States National Institute on Alcohol Abuse and Alcoholism.

"The fact is we don't know why some people can drink without adverse consequences and some cannot; why some people who drink excessively get cirrhosis and others do not; and some get pancreatitis, gastritis, or peripheral neuropathy and others consume the same amount of alcohol and do not," she pointed out.

Dr Chatham told the annual conference here of the Alcohol and Drug Problems Association of North America that in the coming decade she expects to see new non-invasive technology such as PET (position emission tomography) and NMR (nuclear magnetic resonance) scans examine acute and chronic effects of alcohol on the central nervous system "which hopefully will reveal the anatomical and functional sites of abusive alcohol behavior."

Other advances should include scientific examination of the nature and mechanism of alcohol-derived pathology in alcoholic liver and pancreatic disease, and the use of advances in molecular biology to study the biological mechanisms suppressed by alcohol and alcohol abuse.

One of the most exciting advances, Dr Chatham said, is development of a female monkey model which voluntarily drinks alcohol and which has a reproductive pathology similar to the reproductive pathology in alcoholic women.

The monkey model will allow systematic study and evaluation of the effects of alcohol on the neuroendocrine hormones which are essential for reproductive function.

Studies in mice, rats, and primates have found that the offspring of alcohol-fed mothers will be born healthy in spite of early fetal injury if the mother is abstinent in the latter stages of pregnancy.

She added: "This reinforces the credence by observation that women who abstain (from alcohol) the latter half of pregnancy, after heavy drinking in early pregnancy, have borne offspring who apparently are no less healthy than those of women who did not drink at all. Think of the guilt-free message that offers to (those of) us who work with women in the early stages of pregnancy."

Second-hand smoke studies need reinforcing

By Maureen Brosnahan

WINNIPEG — Between 60% and 70% of the general population believe second-hand smoke is dangerous, but scientific evidence documenting its exact effect on non-smokers must be reinforced by further research, says Stanton Glantz, PhD, an assistant professor of medicine at the University of California, San Francisco.

Dr Glantz says he believes thousands of people are dying in the United States each year from smoking-related illnesses. However, without proof, non-smoking advocates have a weak case to present to the powerful tobacco manufacturers, he said.

"I would urge people to make good, air-tight studies (that) I would love to beat the tobacco industry over the head with," he told the 5th World Conference on Smoking and Health here.

He said studies on passive smoking make up only about 1% of all the scientific literature on smoking, yet they are the studies that worry tobacco manufacturers the most.

Richard Peto, MD, of the clinical trial service unit, Radcliffe Infirmary, Oxford University, told the conference that about 100,000 smokers die every year in the United Kingdom and about 1% or 1,000 "are being killed by passive smoking."

But, he said, scientists have not yet demonstrated the exact relationship between these deaths and second-hand smoke.

Dr Peto was responding to Takeshi Hirayama, MD, of the epidemiology division, National Cancer Centre Research Institute, Tokyo. Dr Hirayama presented data from his controversial 1981 study of 265,118 people in Japan over a 16-year period. That study found non-smoking wives of heavy smokers ran twice as high a risk of contracting lung cancer as those married to non-smokers (**The Journal**, April, 1981).

Dr Hirayama's study, which prompted the tobacco industry to embark on a massive advertising campaign to counter his results, also found that the more the husband smoked, the higher the risk of lung cancer to the wife.

More recently, he found such wives also had a three-fold increase in nasal cancer, a 60% increase in chronic bronchitis and emphysema, and a 30% increase in heart disease. Dr Hirayama, who defended his research against various criticisms at the conference, invited others to repeat his study in other countries.

"I myself do not doubt the credibility of my study . . . If there were careful studies in other parts of the world, I think similar things would be revealed," he told **The Journal**. "The purpose of this whole area of research is to search out the tragedy."

Dr Peto, while agreeing that people are dying of second-hand smoke, questioned Dr Hirayama's lung cancer statistics saying they indicate these non-smoking wives are running a higher risk of getting diseases such as lung cancer, than the average smoker.

"Whether they really do represent a cause and effect, I have some doubts," he said. "In my view it still is unclear how much passive smoking affects non-smokers . . . there must be an effect but we haven't got any direct evidence."

Dr Peto said no one has yet studied in depth the effect of second-hand smoke on non-smokers who are subject to it over a long period of time, some since childhood.

"It may be that experience through childhood and adult life may be much more important than in just childhood or just adult life," he said. "Duration matters much more than dose."

Dr Peto said lung cancer is swiftly overtaking other cancers as the chief cause of death around the world. As well, he said many of the deaths are among non-smokers who are victims of others' smoke.

"This is going to be the decade when lung cancer takes over from stomach cancer . . . as the most prevalent in the world," he said.

Drug-addicted nursing pros self-diagnose, self-destruct

By Harvey McConnell

WASHINGTON — Narcotics, not alcohol, is the major drug problem among United States nurses.

"Booze is minor. It is a problem, but narcotics is our big problem," believes Pat Benedict, retired US Navy commander and nurse, and a member of the California task force on chemically dependent nurses.

In Northern California in 1982 some 500 nurses were investigated for suspected narcotic use, she said.

A nurse with a narcotics problem will seldom be approached directly, Ms Benedict told the World Congress on Mental Health here. "The nurse will go from institution to institution and she will be fired, and her problem won't be addressed.

"They won't tell her what to do. If she is suspected of narcotic use, or if narcotics are found missing, the institution will just let her go. She saves face, and they get rid of her, and somebody else has the problem."

Nurses are arrested less often than doctors when driving under the influence of alcohol, and nurses tend to intimidate and put down a male doctor in order to guard their right to drink. Ms Benedict, a recovering alcoholic, added: "We do this out of fear — pure, unadulterated fear.

"We self-diagnose and self-medicate, self-cure and self-destruct."

The greatest fear for a nurse is the possibility of losing her licence to practice, and she will go to elaborate lengths to protect herself. Many, addicted to drugs or alcohol, will choose to work night duty. Often they will go out drinking with doctors who are alcoholic "and that makes it okay."

Nurses are reluctant to address an addiction problem among their peers "and I think there is far less confrontation among nurses than among doctors," Ms Benedict added.

Nurses will talk freely about others being addicted, but not among themselves. Ms Benedict said she and several other speakers produced an extremely hostile reaction at a recent nurses conference when they raised the problem of addicted nurses.

Ms Benedict said nurses mainly abuse Demerol, although there is some amphetamine and morphine use.

Signs which indicate a nurse may be abusing drugs or alcohol are depression, "and they will appear anxious, restless, jittery, less pleasant, and less kind."

Ms Benedict continued: "I think many nurses don't know how, or are unwilling, to ventilate their feelings. They take a lot of the pressure from the job home — the super nurse. Many nurses have poor and distant relationships with their mothers.

"Nurses are perfectionists, are controlling, and have a super ego. They have a lot of self-denial and repressed feelings."

The addicted nurses "eventually will feel helplessness and hopelessness. Helplessness you can pretty well handle, hopelessness you can't."

Nurses: they take a lot of pressure home from the job

Clout allows MDs to cover addiction longer

By Harvey McConnell

WASHINGTON — Doctors with alcohol or drug addiction can get away with it longer than most people because they have more clout in society and can cover it up for a long time.

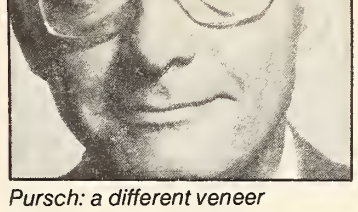
But their patterns are similar, albeit with a different veneer, to those of other addicts, says Joseph Pursch, MD, corporate medical director of CompCare, and former director of the United States Navy's rehabilitation center in Long Beach, Cal.

Dr Pursch, who has treated more than 1,000 doctors in his service and civilian careers, said most addicted doctors are men "although we are now seeing more and more women among them."

He added: "Most of them are somewhat constricted in their behavior to begin with. They are usually compulsive and conformist and too proper for their own good.

"Their dress is ultra-conservative and they don't gamble, and they just don't do a lot of things, and their performance is usually that of the over-achiever. That's how we (doctors) got where we are."

Most doctors who eventually become addicted to drugs at first become addicted to work, Dr Pursch added. "Instead of getting drunk they overdose on work.



Pursch: a different veneer

"But when doctors, or nurses, begin to drink they are the hyper-prototype of what people in the Western world should be: proper, good, ethical — everything. And then they begin to use the chemical, and the family begins to notice they drink and work too hard."

Dr Pursch told the World Congress on Mental Health here, that while the doctor "has a bigger clout in society and can cover it up longer," eventually colleagues begin to notice behavior which is inappropriate for a doctor.

Dr Pursch continued: "Surgeons, for example, will start to restrain their responsibility in operations. They see people more in their office and do more and more bread and butter work.

"And the doctor will become more and more of a patient himself. Most of the alcoholic physicians I have treated have had a series of psychiatrists to evaluate and treat them, but they never give a diagnosis and certainly never one with a good result. Eventually such doctors are unable to make it to work, but by then it is far, far too late."

Dr Pursch said that whether it be a doctor, cab driver, priest, or carpenter — there is no difference — intervention is needed "for anyone who drinks in such a way, and to such an extent, that they repeatedly don't remember on Saturday morning where they were or what they did on Friday. They are very, very sick.

"A social drinker is one who can take it and leave it. An alcoholic can only take it or leave it."

This applies to other chemicals as well, he added. While there are many heroin "chippers" and coke snorters who are not physically in trouble, "they would not even consider having a Friday night without coke because they have become dependent on coke for making out, for feeling with it, for being cool."

Attitudinal shifts are altering health, social picture

By Harvey McConnell

WASHINGTON — A gradual "cooling of America" will have a major impact in the coming decade on health and social problems, particularly in the alcohol and drug fields.

This is the prediction of William Pollin, MD, director of the United States National Institute on Drug Abuse (NIDA), based on what appears to be happening in US society, and which he outlined at the annual conference here of the Alcohol and Drug Problems Association of North America.

"It is clear that from the late 1950s to the late 1960s, the levels of drug use increased by a factor of 10- to 40-fold, but after two decades of steady increases in drug use, it has clearly levelled off, and, in many instances, if you look at overall national prevalence figures, slowly decreased," he noted.

This is part of the changes in patterns which people at the NIDA "semi-facetiously refer to as 'the cooling of America.' "

Dr Pollin continued: "For the first time in 15 to 20 years the divorce rate is coming down, the crime rate is coming down, the adolescent suicide rate is coming down, automobile fatalities per mile driven are coming down, and SAT (student aptitude test) scores are beginning to go up.

"And it is very clear there are some basic changes in this society which will have substantial impact on many health and social problems, and particularly in the alcohol and drug fields."

There is a need to understand how the changes have come about, what are the consequences, what can be done to facilitate those parts of the changes which are positive, and what can be done to make sure the changes are not interrupted, Dr Pollin said.

The other side of the coin "is to make sure we don't get into a 'Pollyannaish' kind of position that the problems are gone. They aren't," Dr Pollin added.

Pollin: cooling of America

The US still has the highest level of drug use of any industrialized society, and drug use is still 10 to 30 times higher, depending on the drug, than it was 20 years ago.

Dr Pollin said in recent years testable, biological hypotheses have been developed which may uncover why some people "are subject to falling prey to addictive disorders while others exposed to the same kind of family, environmental, and social conditions do not."

In the prevention field, the last decade has demonstrated that many approaches "a lot of us were enthusiastic about don't seem to work."

One program which does seem to work, and which the NIDA is supporting with several large-scale studies, is a psychological approach for young people, centered on their being able to say "no." It has been found to work with cigarette smoking and now appears to work with alcohol and other drugs as well.

Dr Pollin said the field must communicate more effectively to politicians, the media, and the nation as a whole the key facts about drug abuse, alcoholism, and other addictive disorders, because of their comparative severity and primacy, and what they require in terms of public attention, public concern, and resources, both public and private.

Former Health and Human Services Secretary Joseph Califano rightly called addictive diseases the country's number one health problem, Dr Pollin said. "When one looks at the poverty, morality, destruction in families and communities, economics, comparative health costs, and the ability of these disorders to corrupt and corrode the political process, I think this is a sound conclusion."

Scotland's drug war gets funding boost

EDINBURGH — More money is being made available by the government to tackle Scotland's growing drug problem and help stamp out what a Scottish Office minister describes as "an evil trade."

The additional funds, from the National Health Service (NHS) budget,will pay for new projects for the treatment and rehabilitation of drug users.

John MacKay, Scottish Office minister for health and social work, said applications would be accepted from health boards, local authorities, and voluntary bodies interested in setting up projects in their areas.

Mr MacKay was speaking after meeting a deputation from Leith, led by local Member of Parliament (Labour) Ron Brown, pressing for more help in fighting the growing drug problem in that area.

Mr Brown said Mr MacKay had offered "sweeties," and he criticized the use of money already earmarked for the NHS by the government.

Mr MacKay said he was concerned about growing drug abuse in Scotland. Last year there were 391 registered drug addicts in the country, but it was estimated that there were 1,500 users.

Mr MacKay said the government move was intended to improve the link between the community and the statutory bodies and increase awareness of the problem.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

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The poor can do without an economic bludgeon

Higher cigarette tax a deceptive solution

Increasingly, we're seeing price increases advocated as solutions to addiction. It's a rather impersonal bureaucratic approach to very human problems. The latest instance is the proposal of the usually astute and thoughtful Richard Gilbert for a whopping increase in tobacco taxes (**The Journal**, August). If we're going in this direction, we'd better be clear on why, and with what results.

Let's assume that a given increase in taxes is followed by a 20% decrease in cigarette sales. Logically, this can mean one — or some combination — of two possibilities. One would be that 20% of all smokers will quit. But which smokers? If we accept a continuous distribution model, those most likely to quit would be the lightest smokers. But, those who are smoking heavily, those at greater risk, would be considerably less likely to quit. In other words, the strategy would not affect those who most need to change.

The other possibility, also consistent with a single distribution model, would be a 20% reduction in the number of cigarettes smoked by all smokers. This would convert

Sadava

Gilbert

high-risk smokers to what would appear to be a less hazardous pattern of consumption. However, much of the research shows tendencies toward maintaining a constant level of nicotine, which suggests compensatory smoking. They may smoke 20% fewer cigarettes, but may inhale more deeply and more frequently and smoke down to the butt — thus increasing their exposure to tars, carbon monoxide, and various other toxins and pollutants.

Dr Gilbert has recognized this problem when discussing "safe cigarettes" (**The Journal**, July, May 82). Why forget it now?

The other argument might be the deterrence of smoking among teenagers. I'm not convinced. The escalating price of beer and other alcoholic beverages doesn't seem to deter teenage drinking. Video games, at 50¢ a shot, continue to be big business. If they want to smoke, they'll somehow find the money.

This kind of price increase would be an irritant to the upper-middle-class smoker. To the unemployed person, the woman on mother's allowance, it would be a hardship. Adding one more stressor to a stressful life is hardly helpful to a smoker who might want to quit. These people would certainly be better off without cigarettes, but they don't need an economic bludgeon.

In our eagerness to solve addiction and health problems, we must be sensitive to the possibility of creating other problems, particularly for people who are vulnerable. We'd better have much more fine-grained analyses of these problems before we jump into deceptive solutions; we surely don't want to enhance public health on the backs of the poor.

Stan W. Sadava, PhD
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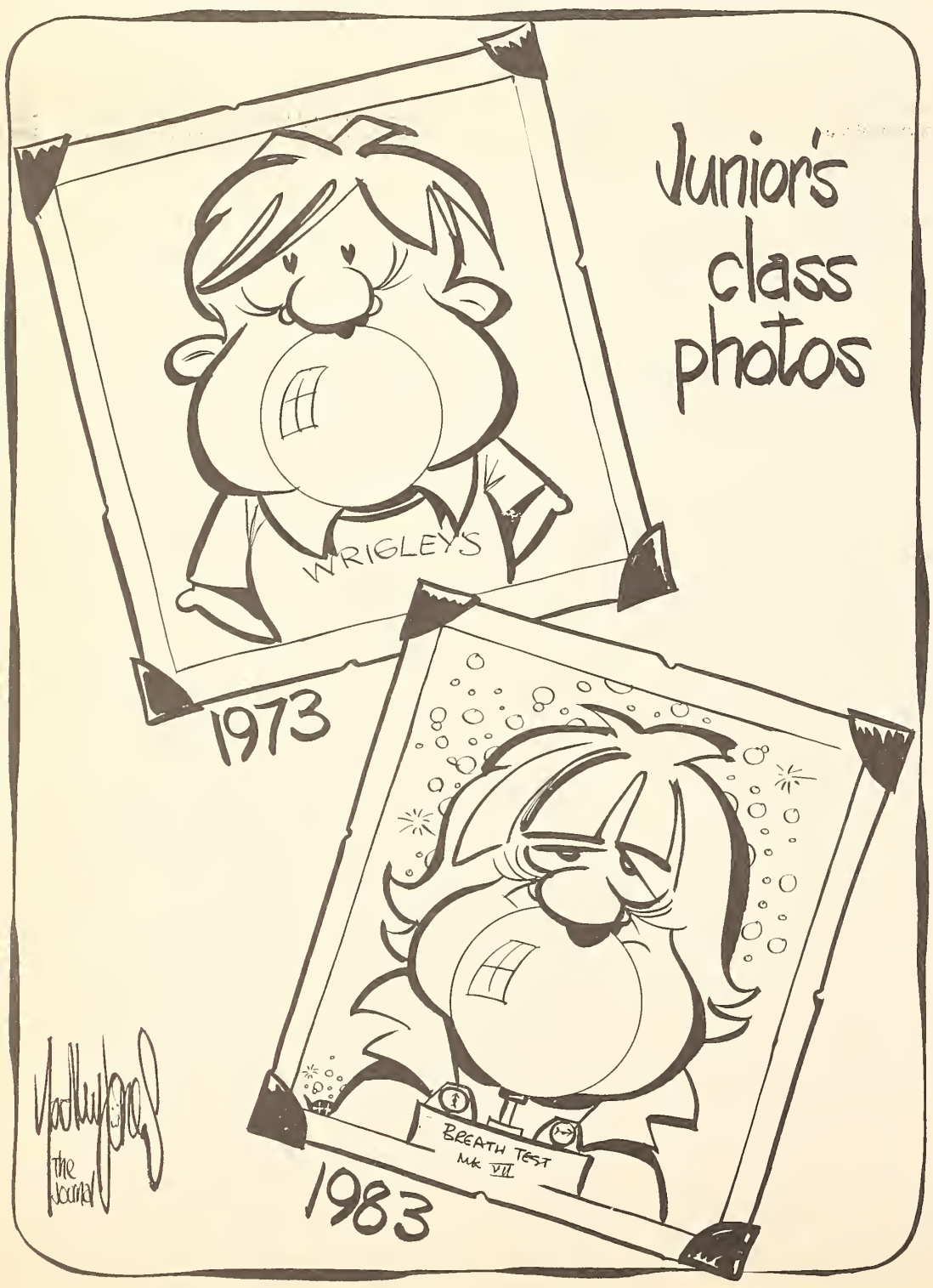


Liquor ads need limits

In light of the virtual ubiquity of alcohol advertisements in the electronic media, coupled with their obvious persuasiveness not only on the targeted market but also on the under-aged viewing public, debate on the suitability and influence of this practice should be considered.

The advertising trend in recent years has been to condition the consumer to associate pleasurable activities with alcohol consumption, a trend, it should be noted, which has been highly successful.

The Swedish example of limiting alcohol advertisements to the print media alone deserves serious consideration.

Gordon F. Phaneuf
Ottawa

Fed jobs do go to under-21s

In Richard Gilbert's column (The Journal, Sept) he states that one must be 21 years of age to be a federal public servant.

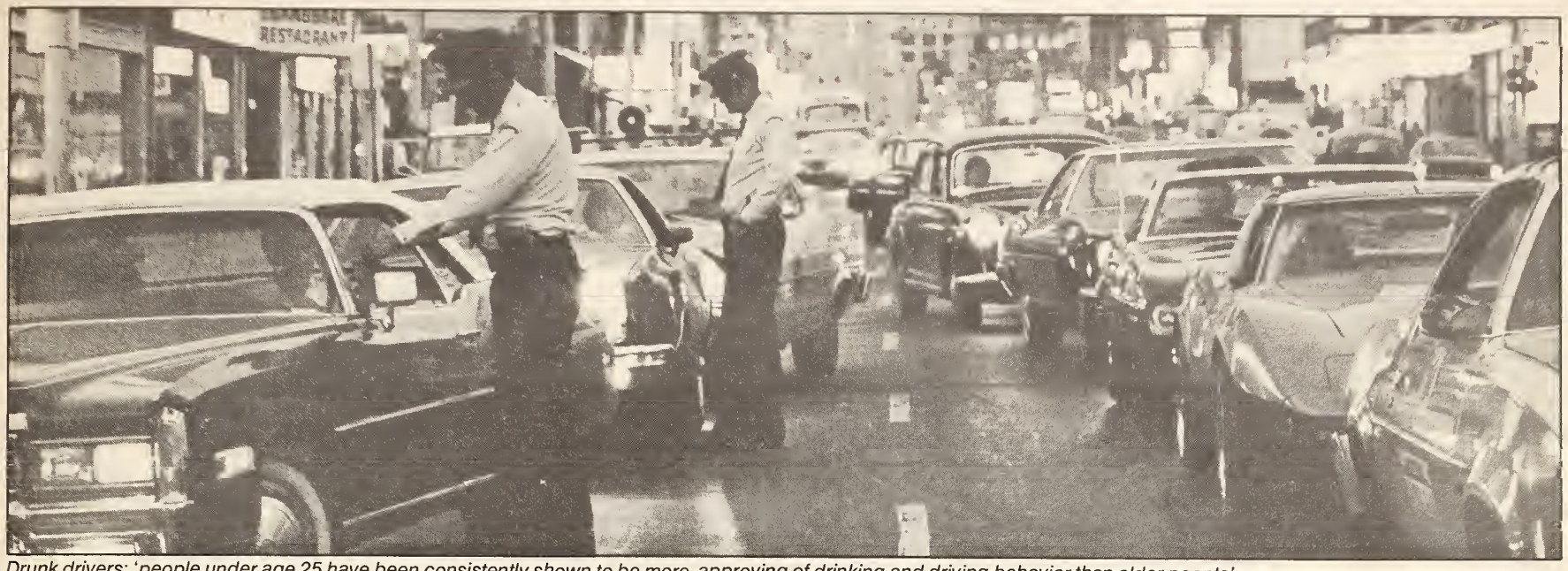
I am 21 years old and have been working for the department of Labour for three years. What is this? Have the laws been changed? No, I discovered. One may work for the federal public service at the age of 17, or under the age of 17, provided the conditions of the Labour Standards section, Part III of the Canada Labour Code are met.

On behalf of myself, and other federal public servants, could you please inform Dr Gilbert of his mistake? This lack of research on his part lends serious doubt to the credibility of his entire article.

Janine Lamontagne
Human Resources Planning
Personnel and Management Services
Labour Canada
Ottawa

Dr Gilbert replies: I was wrong. My source for the information that "federal civil servants must be 21 years of age" was an article by Dr D. A. Wilkinson in *Social Science and Medicine* (volume 15F, 1981). His source was an official in the Ontario Ministry of the Attorney General. Because of the surprising nature of the information I should have checked it out myself. I did on reading Ms Lamontagne's letter. Lise Martin of the secretariat of the Public Service Commission in Ottawa confirmed each one of her points, adding that the term "civil servant" had not been used since massive change in federal legislation in 1967.

***The Journal* welcomes Letters to the Editor. Letters may be sent to the Editor, *The Journal*, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.**



Drunk drivers: 'people under age 25 have been consistently shown to be more approving of drinking and driving behavior than older people'

Drinking age debate misses point

Messages to youth need to be consistent

Shortly after Toronto City Council asked the province of Ontario to raise the drinking age to 21 years, its two-year-old request for an extension of licensed facilities to the cafeteria serving city hall employees and the public was implemented.

Perhaps nothing could better symbolize why raising the legal drinking age, as an isolated measure, is unlikely to achieve Council's goal of eliminating the over-representation of teenagers in alcohol-related road accidents. As long as the identification of alcohol as an integral element of adult status increases, legal sanctions will have disappointing results.

There is no doubt Toronto Council is on the right track. The City and its Public Health department have played a vanguard role in the increasingly successful multi-level public effort to reduce cigarette smoking. Yet, this strategy has been aimed simultaneously at both youth and adults, and there's strong evidence that the decline now being reported in teenage smoking *followed* an initial decline in adult tobacco use.

Serious attention

The drinking and driving problem deserves even more serious public attention. Not only has the Canadian Medical Association (CMA) identified alcohol as "the greatest public health problem in Canada," the drug also plays the leading role in traffic fatalities. The Traffic Injury Research Foundation in Ottawa says traffic fatalities account for almost half of all deaths among Canadians aged 15 to 19 years and about one-third of deaths of young adults aged 20 to 24 years.

There is little doubt that for some states in the United States restoring the drinking age to 20 or 21 years has at least helped to prevent further escalation of teenage motor vehicle crashes and fatalities.

Massachusetts, for example, raised its legal age to 20 years from 18 years in 1979. When the average of teenage fatal accidents during the three years preceding the law was compared to the average the first two years following the hike, fatalities had dropped 1%. In New York state, however, which kept its legal age at 18 years, crash fatalities involving teens increased by 5% in the same two-year period in upstate counties not bordering on Massachusetts.

However, higher legal drinking ages have not eliminated drinking and driving as a leading cause of death among young people.

Michigan was one of the first states to raise its legal age to 21 from 18 years at the end of 1978. While the total number of accidents involving teenage drinking drivers has declined, teens' representation in fatal accidents involving alcohol remains particularly high. In early 1973, when the legal age was still 18, 18- to 20-year-old drinking drivers accounted for 19% of all alcohol-related fatal accidents while representing a stable 8.4% of licensed drivers in the state. At the end of 1982, four years after the drinking-age revision, the now under-age drinking drivers still accounted for 16.9% of all fatal alcohol-related accidents.

More approving

No matter what the legal drinking age, or the jurisdiction, people under age 25, as a group, have been consistently shown to be more approving of drinking and driving behavior and to engage in it more often than older people. A 1978 US survey of student drinking practices showed that among states with a traditional legal age of 21, an average 19% reported that on occasion they combined drinking and driving — only 4% fewer than the average for states with legal ages under 21 years.

It is reasonable to anticipate that raising the legal age would reduce alcohol-related road problems as a natural consequence of reduced teenage consumption. Indeed, the evidence is clear that the lowering of the drinking age in Ontario and in states such as Michigan in the early 1970s significantly stimulated an already-accelerating rate of teenage drinking. Yet raising the age appears to have had little or no impact in the opposite direction.

Moving the Ontario age upward by a year in January 1979 seemed to result in a slight drop in drinking for teenagers who drank infrequently, but there was no apparent change for regular under-age users. And, in the two years following Massachusetts' hike to a legal age of 20 in 1979, teenagers there shifted sources of supply but not drinking levels.

Drink at home

Availability of alcohol from several sources remains high. But nowhere have outside sources rivalled the importance of the family home. In Massachusetts, in the two years following the enactment of the new legal limit (20), the number of teenagers for whom "home" became a major source of alcoholic drinks nearly doubled.

In the years immediately preceding and following the lowering of the drinking age, parental attitudes to teenage use of alcohol seem to have undergone a revolution that current legal changes have not altered. In a late 1960s survey of adolescent drinking in 10 northwestern Ontario communities, more than one in three teenagers reported their parents to be either in favor of their drinking or unconcerned. An overwhelming majority of parents who were aware of their children's drinking habits were reported either to have done nothing or to have expressed "mild concern."

The unprecedented growth in teenage alcohol and other drug use in the past two decades has been very much a mirror-image of increases in older-adult, legal, per capita consumption. Yet the emergence across the continent of powerful, parent anti-drug groups has invalidated the previous assumption that involving parents in alcohol prevention issues was an unreachable goal.

Nor do the parallels between teenage and adult behavior end here. Evidence is accumulating that, like adult drinking drivers, the majority of teenagers involved in alcohol-related accidents may be "problem drinkers."

Parallels

Since raising the age limit, several US states have noted significant reductions in the reporting of alcohol-related, property-damage-only crashes, but no apparent effect on the incidence of alcohol-related injury and fatal crashes.

Since research has consistently shown that drinking drivers involved in the most serious crashes are likely to drink more on any drinking occasion than their peers involved in property-damage-only crashes, it appears that teenage "problem drinkers," as is the case with adults, are less deterred by legal sanctions. For instance, an officer with the Michigan State Police Traffic Services Division informed me the average blood alcohol readings for under-age drivers involved in accidents there have consistently risen since the raising of the legal age.

It seems a major reason why the new US drinking age laws have failed to restore the pre-1970s situation on the roads is that teenage drinking drivers now include a large group of problem drinkers that did not exist in the 1960s. Ontario's situation appears to be similar, as indicated by the startling increase in the past decade in the proportion of teenagers among drinkers seeking treatment services in the province.

Problem behavior

The typical under-age drinking driver has been profiled in several US surveys and studies, all of which have portrayed an individual involved in many illegal and problem behaviors.

Perhaps the most significant element in the existing profiles is the fact that subjects tend to be contemptuous of laws which they feel are inconsistent and discriminatory. And what could be more inconsistent than a drinking age of 21 in a province where a barrage of alcohol advertising is directed to youthful audiences?

A Michigan State University investigation has indicated that alcohol advertising promotes favorable attitudes to driving under the influence, particularly among teenagers and young adults. The study concludes the higher the exposure to alcohol advertising, the more likely a young person is to drink and drive, drink while driving, or drink while sitting in a parked car, and to believe that their driving ability won't be affected.

It appears a helpful factor in the decline of teenage smoking has been a sharp reduction in cigarette 'lifestyle' advertising. In these restrictions, the City of Toronto's health department has played an active role, prohibiting cigarette ads in any property owned by the City. Yet no municipal government has seconded the CMA's 1981 call for a ban on alcohol advertising. During the week that Toronto Council debated its drinking age resolution, a Toronto teenager could have attended a rock concert sponsored by a brewery at Exhibition Place, drunk beer at the ballpark, or trained for a brewery-sponsored marathon, all while humming a tune from a TV beer commercial. Such inconsistency is puzzling.

Consistency

Where youth are concerned, nothing could be more important than consistency.

In Ottawa, Justice Minister Mark MacGuigan, who has promised new measures to deal with drunk drivers (see page 1) should by now be familiar with several innovative foreign approaches that combine control and early intervention for the problem drinker of any age.

We can also learn much from US strategies which supplement sanctions with successful educational approaches, and which, on a national scale, are aimed at giving youth a meaningful role in helping to solve the wider drunk-driving problem.

Yet it may take a royal commission on alcohol, also called for by the CMA in 1981, to get at the essential contradiction we face in seeking to eliminate from young adults behavior whose public image adds up to healthy, adult living.

By Don Smyth

Mr Smyth is a private consultant on alcohol and drug abuse preventive programming based in Toronto.

INTERNATIONAL

Addiction may be highest on continent

Poland ends pretence, clamps down on heroin

By Thomas Land

GENEVA — Poland is expected shortly to introduce legislation to control opium-poppy cultivation and to stamp out the illegal production and sale of heroin.

The law, to be backed up by an emergency rehabilitation and treatment program for young addicts, has been provoked by the drug-related deaths of 80 young people last year and more than 120 so far this year. This may be the beginning of a series of drug-control measures in Eastern Europe ending the pretence that narcotics abuse — officially associated there with Western "decadence" — does not exist in the region.

The world's largest producer of morphine, Poland may well have the biggest drug addiction problem on the continent. The issue has been brought into the open first by the newspapers during the brief months of relative freedom generated by the rise of the Solidarity movement — and later by the government which is pleased to draw attention to problems other than the repression of free trade-unionism.

The weekly journal *Polityka* puts the number of Poles regularly involved in the illegal production and distribution of heroin at 10,000. The youth newspaper *Sztandar Mlodych* estimates conservatively the number of heroin addicts in the country at 150,000, most of them aged between 13 and 30 years. In a review of anti-narcotics legislation around the world, the government newspaper *Rzeczpospolita* wonders aloud whether the proposed Polish measures are tough enough to deal with the emergency.

At least 300,000 acres of prime agricultural land is devoted to opium-poppy cultivation in Poland to produce an annual harvest of 10 million kg for legitimate pharmaceutical use. But the dry poppy stalks containing the drug can also be used to make high-quality heroin. And the independent — and profit-conscious — Polish peasants can raise an income from the black market that dwarfs the official prices paid for their produce by the state-controlled pharmaceutical industry.

The lax anti-narcotics laws coinciding with the easy availability of heroin and the uniform drabness of life yawning at a politically-disillusioned generation of young people have combined to create a rapidly spreading drug disaster.

For several years, Poland has drawn young visitors interested in experimenting with drugs from both sides of the divided continent. But the East European governments, schools, health services, and youth organizations have hitherto claimed they did not have a drug-addiction problem — and their young people were consequently unprepared for the experience. Unlike Western youngsters trying various pills as well as marijuana, giving themselves a chance to stop before they are hopelessly addicted, the East Europeans frequently begin with heroin.

The under-financed health services of the region are equally unprepared for the emergency. Warsaw, for example, which has recently emerged as the heroin Mecca of Europe, has fewer than a dozen detoxification beds, all of them located at a single hospital. The entire country has only five small treatment centres.

But all this is to change. The new law is to prescribe long prison sentences for illegal drug manufacture and distribution. All opium-poppy production is to come under state control. The education, health, and social services are to treat drug abuse as a matter of urgent priority.

These hastily assembled measures offer little immediate relief to Poland's drug generation. But the public acknowledgement of the problem may at last trigger mature discussion leading to appropriate policies to confront drug addiction throughout Eastern Europe.

WHO expert group still pushing for controls on benzodiazepines

By Behrouz Shahandeh

GENEVA — An international committee of experts has once again recommended benzodiazepines be brought under control.

At the World Health Organization's (WHO) 8th Review of Psychoactive Substances for International Control held here in September experts urged that 33 benzodiazepines, including diazepam (Valium), be included in Schedule IV of the 1971 Convention of Psychotropic Substances, Dr Inayat Khan of the WHO's Drug Dependence Program told **The Journal**.

The meeting was convened at the request of the 30th session of the United Nations Commission on Narcotic Drugs held in Vienna in February. At that time, the Commission failed to reach the necessary two-thirds majority to approve a recommendation by the WHO for control of 26 benzodiazepines (**The Journal**, April).

The September meeting included 11 experts and a number of observers representing the UN Division of Narcotic Drugs, the UN Fund for Drug Abuse Control, the International Narcotic Control Board, the WHO, ICPO/Interpol, and the International Council on Alcohol and Addictions.

Thirty-nine benzodiazepines were presented for the scrutiny of the experts but only 38 were eligible for review according to the Commission resolution which had specifically asked that benzodiazepines on the market at the end of February, 1983, be studied.

The experts reviewed the pharmacology and dependence studies in both humans and animals, public health aspects, social consequences, as well as data related to illicit manufacture and trafficking of this group of drugs. Five substances were shelved temporarily because of the inadequacy of information required for international control, Dr Khan said.

The recommendation, after approval by the director general of the WHO, will be submitted for consideration at the forthcoming special session of the Commission in Vienna, February 6-10, 1984. Observers said the short duration of the special session and the fact that the Commission membership has been enlarged from 30 to 40 (**The Journal**, July) will add further dimensions to the already difficult task of obtaining the two-thirds majority or 27 affirmative votes.

However, the brevity of the session may also prevent counter-lobbying by the pharmaceutical industry. The prevalent opinion among observers is that much intense diplomatic activity is required between now and February to gather the votes needed.

In the meantime, Dr Khan said the entire process of the review of psychoactive substances for international control is to be re-examined at the January meeting of the Executive Board of the WHO. This follows a recommendation by the review committee. Among issues to be discussed is the sensitive matter of participation of the pharmaceutical industry in the control process and whether that representation should be limited to scientists only or should also include representatives from marketing and sales. One proposal is to hold meetings for exchange of views with industry representatives just prior to the review meetings.

Swedish officials startled by urine test results

By Anne Kershaw

OTTAWA — Urine tests are being used increasingly in the fight against drugs in the Swedish correctional system, a prison psychiatrist told the 2nd World Congress on Prison Health Care here.

However, despite increased use of the tests, the number of positive finds has remained relatively constant.

This was somewhat startling considering the general perception of almost uncontrolled drug abuse at a large number of prisons, said Kjell Bjerver, MD, PhD, a senior psychiatrist with the Karolinska Institute in Stockholm.

Dr Bjerver said the number of analyses carried out tripled in one year to 1,932 in 1982. In addition, the number of prisons which make use of specimen taking has nearly doubled.

While the method of analysis used by the country's national forensic laboratory is sensitive enough to show positive results for small amounts of the suspected substance, it is not specific.

For example, codeine, often used in painkillers, gives a positive result. Consequently, verification must be made through other methods.

The question now being asked is whether reports of misuse have been exaggerated or whether the tests have acted as a deterrent. But, Dr Bjerver said, physicians have not ruled out the possibility that prisoners have learned new ways to hide misuse or have switched to drugs which aren't included in the analysis.

"Knowledge of the various drugs' chemistry is not low among misusers. They often know more than the majority of those conducting the tests," Dr Bjerver said.

It has also been reported a large number of tests have been manipulated through dilution. The prisoner drinking large quantities of water before sample-taking can mask the use of certain substances, most notably heroin and amphetamines, which the body can break down in a relatively short period.

Conversely, because the breakdown of cannabis takes place over several weeks, tests can be positive for a long period after use, complicating follow-up measures.

The unreliability of the test became particularly clear when there was a positive morphine find in one prisoner who had eaten pastries containing poppy seeds.

"An important rule is that a positive urine sample must always be placed together with other observations if it in any way is to lead to negative consequences for the inmate," Dr Bjerver said.

However, he believes the tests have not only significantly curtailed drug use, but the staff at several prisons have also "dropped their pessimistic passivity" because they have a new tool to aid in controlling misuse.

Dr Bjerver said there are now legal ramifications for prisoners who refuse to supply a sample or whose urine is found to contain evidence of drug misuse. A prisoner's parole or leave may be affected, for instance.

The number of addicts in Sweden's correctional system is currently believed to be 31.4% of the inmate population and 21% of those on parole.

At the Stockholm Remand Prison, the largest in the country, a 1982 study spanning five years showed that only 11% to 16% of the inmate population said they didn't use any form of drug or alcohol.

Dr Bjerver said interviews with prisoners indicate only 30% of drug users had received any form of treatment before going to prison. This was likely for a short period as a result of acute poisoning or self-inflicted injury connected to misuse, Dr Bjerver said.

Israel warned of rise in heavy drinking

By Terry Brodie

TEL AVIV — While Israelis still lag far behind their Western counterparts in consumption of alcohol, there is reason to believe the gap may narrow in the future.

So says a recent study carried out by two researchers for the Service for the Treatment and Prevention of Alcoholism run by Israel's Ministry of Labor and Social Affairs.

The study, which surveyed 1,033 Israeli adults last year, found that 58% of Israelis rarely or never drink alcohol, except on religious occasions, and between 29% and 33% infrequently or never serve alcoholic beverages at festive meals or social gatherings.

In addition, 74% say they have never been intoxicated, 55% say they do not know an alcoholic, and 72% are hardly or not at all disturbed by their own or their family members' drinking.

But 2% of Israelis drink alcohol daily, and 5% drink at least every two or three days. In addition, 14% of the Israeli public are greatly disturbed that they or a family member drink.

"This serves as a warning that a problem may develop in the future," says the study.

It also points out that 3% of the survey's respondents get intoxicated about once a month, 29% know at least two people who drink every day, and 15% say they are acquainted with at least two alcoholics — people defined as unable to function without daily use of alcohol.

And 17% of those questioned say they drink for reasons the study's researchers, Chaviva Bar and Reuven Boymel, believe "could lead them to addiction." The motives include drinking to improve bad spirits or depression; to relax or alleviate tension or pain; to escape worries; to sleep well at night; and to overcome feelings of hopelessness or helplessness about the future.

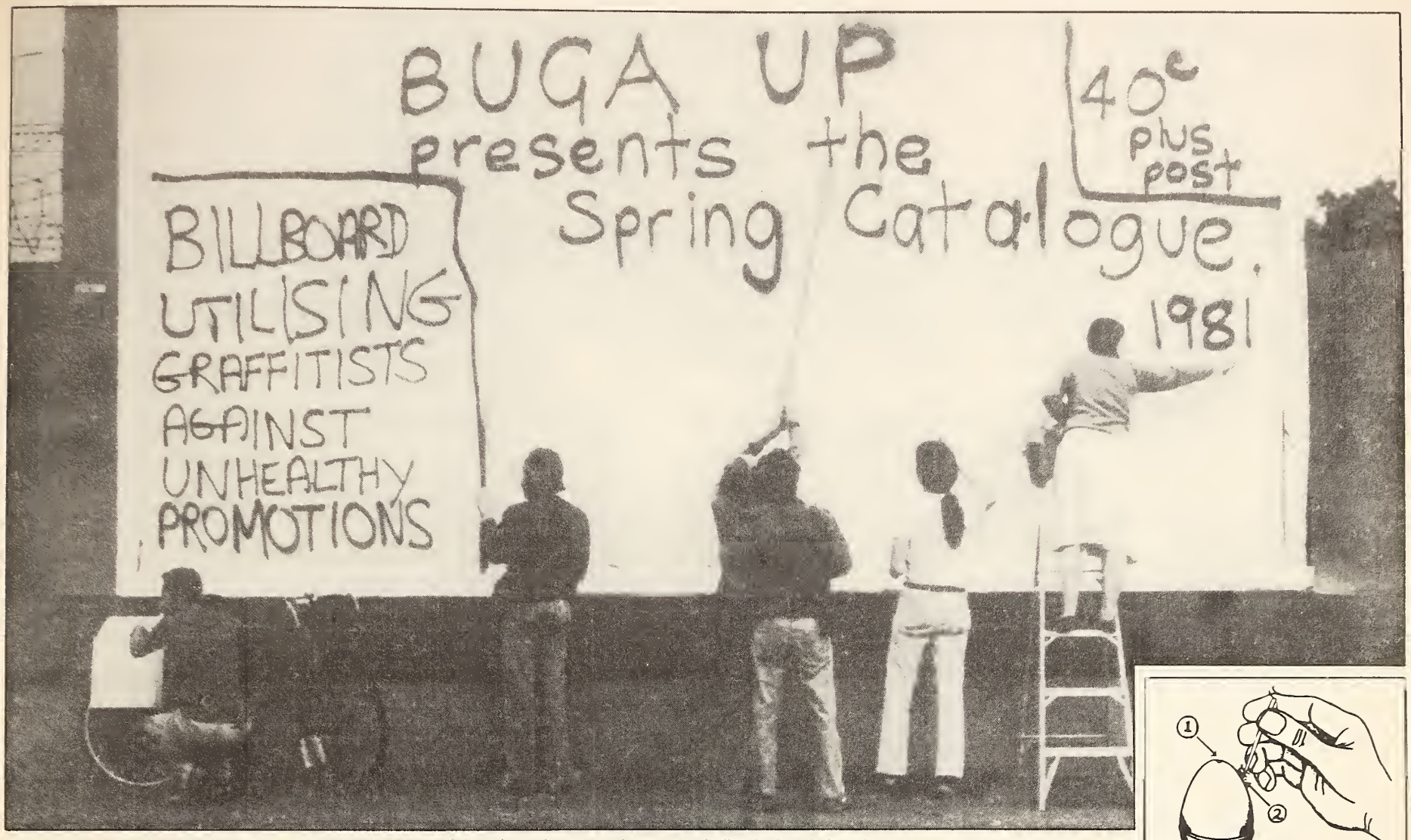
The survey also found 1.1% of the Israeli public comes in very close contact with alcohol: these people drink at least every two or three days, become intoxicated at least once every few months, know at least two daily drinkers, and are greatly troubled by their own or family drinking. This group, says the study, "most indicates the existence of alcohol-related problems."

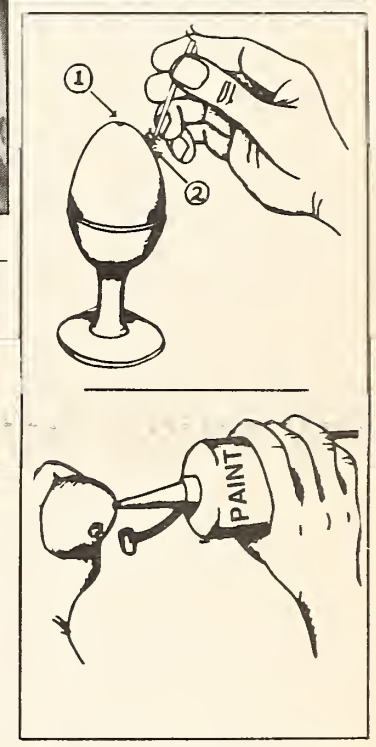
Use of alcohol is more widespread among Israeli men than women, regardless of their country of origin the study reports.

In addition, it is the young, aged 20 to 24 years, who report having been drunk or serving alcohol on social occasions more than any other age group. More work, advises the study, should be done with the young.

The Service for the Treatment and Prevention of Alcoholism, which now runs about 10 treatment centres in Israel, estimates there are about 7,200 alcoholics in the country. But the study calls that a "most careful figure" and suggests its findings show a "possible increase in the future."

Israel smoke-bound p16





BUGA UP: demonstrations of billboard 'refacing' methods (above) and how to make an eggshell paint bomb (right)

'Big money doesn't beat dedication'

Graffitists take on cigarette ads

By Mark Kearney

WINNIPEG — Arthur Chesterfield-Evans had watched a number of his patients die from cancer.

He was horrified by the damage "bloody cigarettes" were doing to these people. He joined anti-smoking associations and participated in letter-writing campaigns to try to curtail the damage.

Frustrated by the lack of success of these conventional approaches, Dr Chesterfield-Evans, an Australian MD, turned to what he believed was the only solution.

He decided to break the law.

Dr Chesterfield-Evans became a "member" of BUGA UP (Billboard Utilising Graffitists Against Unhealthy Promotions), an informal band of Australians who, in recent years, have become somewhat of a thorn in the side of tobacco manufacturers (**The Journal**, July).

Although the BUGA UP people use a number of methods to draw attention to the unhealthiness of cigarettes, they are principally known for arming themselves with spray paint cans and defacing tobacco billboard advertisements.

Dr Chesterfield-Evans is one of five Australian doctors who have been charged with willfully defacing advertisements.

The threat of legal action hasn't deterred him or any other BUGA UP member and hasn't hurt his medical practice, he told **The Journal**. Dr Chesterfield-Evans says the Australian public is behind the BUGA UP group because it is seen as an underdog battling the tobacco giants.

"Our goal is completely to eliminate advertising of products that are unhealthy. Within five years I think we'll have (done so) for cigarette billboards.

"Big money beats little money, but big money doesn't beat dedication."

Members of BUGA UP, which started in Sydney in 1979, have been labelled radicals and vandals for their acts of civil disobedience; even Dr Chesterfield-Evans thought of them as "comedians" at first. However, the group's approximately 100 members include doctors, university professors, and other professionals.

Despite their dedication and concern, the BUGA UP group has captured the imagination of the Australian public because of its use of humor against tobacco companies, Dr Chesterfield-Evans says.

This advice is from BUGA UP's do-it-yourself graffiti guide issued in 1981:

"Try to break down the power of the billboard ad by answering it, looking at the space available and the way in which the words and images lend themselves to addition, alteration, or comment. We've found humor to be extremely effective in exposing the advertiser's real intentions — turning the ad's message back on itself."

Some examples of ads that have fallen victim to BUGA UP's spray paint are one for Dunhill cigarettes which was changed to "Lung Ill," and another for Rothmans King Size which was changed to "Rot Mans Lung Size."

The BUGA UP group has also made its presence known at various sporting and cultural events sponsored by tobacco companies. At a tennis tournament sponsored by Marlborough cigarettes, people from the group wore letters on their chests that spelled out "cancer" and sat in seats beside each other where they could be easily spotted by television cameras.

At the same tennis tournament, a child's carriage had a sign on it saying "If I smoke Marlborough, I'll be a jockey not a tennis player."

At a tobacco company-sponsored ballet performance, BUGA UP members handed out pamphlets and carried signs saying "Smokers are dying to bring you the ballet."

"We've made cigarette advertising an issue," says Dr Chesterfield-Evans, adding that previous methods of protesting against tobacco companies have gotten nowhere. "Never had so much been tried so legally for so long for so few results."

Simon Chapman, a council member with the Australian Consumers' Association, agrees orthodox approaches fail to make an impression on politicians who are in a position to bring about change.

The tobacco industry "masks the grim reality" of the health consequences of smoking and can only be counterattacked by "carefully aimed and disruptive action," he says.

Groups such as BUGA UP "jerk the public consciousness of tobacco back to its health effects," says Mr Chapman, who is also the author of *The Lung Goodbye*, a manual of tactics for counteracting the tobacco industry.

The question remains as to whether the BUGA UP movement can expand successfully beyond Australia. Mr Chapman says it only takes a few people to get the movement started and, with North America's longer tradition of street theatre, there should be no problem setting up a similar group here.

Dr Chesterfield-Evans and Mr Chapman were in Winnipeg for the 5th World Conference on Smoking and Health.

Billboard graffiti: turning the ad's message back on itself

NEWS

Nova Scotia considers alcohol tax earmarked for rehab, education

By Incor Jowat

HALIFAX — A drive by Nova Scotia's Commission on Drug Dependency to have the province institute a rehabilitation tax on alcohol will eventually succeed, says Marvin Burke, chief of the commission.

"I feel we will eventually get it, I really do, because it's a logical thing.

"We think that a 1% tax on alcoholic beverages bought in the stores and increased by 1% thereafter each year for five years up to a maximum of 5% would, in fact, provide us with sufficient funds to do the things we have to do."

Mr Burke foresees such a tax as providing money to fill gaps in services and provide necessary funding for education and prevention programs.

The idea, currently being considered by the government's management board, has its supporters and detractors in Cabinet, Mr Burke told **The Journal**.

A spokesman for the provincial health department said the concept has been discussed a number of times, but there is concern in government circles about instituting another dedicated tax.

Mr Burke said politicians fear that if the rehabilitation tax is instituted, "everybody" will want a dedicated tax.

He said another concern is that such a tax will add to the already rapidly increasing cost of alcohol in Nova Scotia and will hurt tourism.

"I don't believe that at all." Factors such as poor services and inadequate hotel accommodation hurt tourism more, he said.

Mr Burke said the concept of the tax is working successfully in New Zealand and in 19 to 20 states in the United States.

Despite the desire for more funding, Mr Burke believes the commission, with a budget of $5.5 million this year, is doing an excellent job.

The commission's decentralized and community-based treatment system continues to attract worldwide attention. (Mr Burke will deliver a paper on Nova Scotia's methods at the Pan Pacific Conference on Alcohol and Drugs in Hong Kong later this month.)

Burke: a logical thing

The system has five regional treatment centres and 26 out-patient centres across the province, with a volunteer advisory board for each region and local committees in each area that has an out-patient centre.

Volunteers also teach senior high school students how to teach drug education to junior students.

Started a couple of years ago, this program has expanded rapidly and Mr Burke said the commission has been given federal funding to prepare three textbooks on this student program.

Herb 'highs' potentially dangerous

CALGARY — Many people are turning to legally-obtainable herbs for their highs, claims a United States health educator.

William T. Jarvis, PhD, professor of health education at Loma Linda University, Loma Linda, Cal, told the Canadian Dietetic Association's annual meeting here that many herbs available on the open market have "pharmacologically-active properties." Dr Jarvis questioned why the US Food and Drug Administration (FDA) has not acted to restrict availability.

Dr Jarvis told **The Journal** a recent study indicated 42 potentially-dangerous herbs are being stocked in health food stores. "You go into a health food store, see a whole rack of herbs and a book that says: 'the Indians used this herb to cure leprosy or whatever.' You read the book and experiment on yourself. It's self-medication from a food store," he charged. "The FDA should look into this."

Dr Jarvis cited belladonna, ginseng, lobelia, and licorice as examples of 15 pharmacologically-active herbs his students discovered on the shelves of some 23 health food outlets near the Loma Linda University campus.

In his address, entitled Food Faddism, Cultism, and Quackery, he argued that "a direct parallel (exists) between drug dealers and pushers of food fads, in that both encourage and exploit dependency."

Dr Jarvis said the "extreme vegetarianism" of macrobiotics exemplifies such dependency. "Most drugs are herbals, such as cocaine, mushrooms, opium, marijuana. People think they're okay because they're natural. It's their choice of a way to cope.

"People who, because of cultural and personal values, wouldn't think of turning to drugs or alcohol to control daily stress, will turn to the teachings of a food 'guru.' They think: drugs are bad, herbs are good," he said.

There is some literature to support Dr Jarvis' contentions, though he admitted "statistics are hard to come by." In the Aug 2, 1976 edition of the *Journal of the American Medical Association*, Ronald K. Siegel, PhD, noted "a substantial increase in both the medical and non-medical use of herbal products, including cigarettes, smoking mixtures, tea, and capsules."

Dr Siegel said: "While the use of herbal medicines dates back to ancient Chinese and early Greek practices, non-medical experimentation with herbal intoxicants is enjoying a recent revival as users search for legal alternatives to the ever-increasing list of restricted drugs, particularly hallucinogens. Indeed, most of the herbs listed are promoted and used for their apparent hallucinogenic, euphoric, or marijuana-like effects."

Said Dr Jarvis: "Like drugs and alcohol, food cults and fads can be a self-destructive way of handling stress for some people."

Burke credits brewers for drunk-drive adverts

HALIFAX — The chief of Nova Scotia's Commission on Drug Dependency has applauded the decision of a Maritime brewery to participate in a $1 million national television advertising campaign aimed at stopping drinking drivers.

"They're going to spend money on an advertising campaign and that's fine," said Marvin Burke.

"I give them full credit for doing that."

Oland Breweries, which markets beer in Nova Scotia, New Brunswick, and Prince Edward Island for its parent company, Labatt's Ltd, announced in September it would join the Labatt's campaign already underway in Alberta, Ontario, British Columbia, and Quebec.

Mr Burke said obviously more than public well-being was considered when Oland decided to finance the anti-drinking driving commercials.

"Where it's a profit-loss situation you don't do too many things that aren't self-serving, and that's fair as long as the general public benefits."

Some people have been critical of the advertising because it places the name of the brewery in the public eye.

NB seeks tough, compassionate DWI strategies

FREDERICTON — A new front in the battle to reduce impaired driving has been opened by the Alcoholism and Drug Dependency Commission (ADDC) of New Brunswick, with the appointment of a three-member committee to develop strategies on the problem.

Judge Douglas Rice of St Stephen will chair the group, with ADDC members Arlee D. McGee of Fredericton and Robert M. Scott of Saint John the other two appointees.

Commission Chairman Everett G. Chalmers, MD, noted the ADDC had attempted in the past to inform the public of the serious injuries and fatalities occurring on the highways.

He referred to an educational program begun three years ago in two or three centres, and said the ADDC hoped to have 12 centres participating by year-end.

"Drunk drivers are a real menace, and something must be done to remove them from our highways," Dr Chalmers said. He said that in America someone is killed every 23 minutes by an intoxicated driver, yet only one impaired driver in 2,000 is caught, and only a small percentage convicted.

The ADDC chairman called for both tough laws and judicial compassion. He said since court referral to DWI (driving while intoxicated) programs exists at the discretion of judges, "any future programs must depend on the continual and increased willingness of judges to find out if DWI offenders are chemically dependent and, if so, to agree to a common penalty, jail term, probation period, treatment, and rehabilitation program."

The future of the system "also depends on the judicial compassion, attitude, and eagerness to put alcoholics into treatment and rehabilitation programs, instead of jail," said Dr Chalmers.

"Tough new laws and strategies are part of the answer, but awareness, knowledge, social change, and education" are equally important, he said. He suggested court referrals would ease judicial caseloads while aiding the individual, adding "because an individual goes to jail for a driving-while-impaired offence does not mean he should not have treatment for his problem."

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

Where's Shelly?

Number: 577.
Subject heading: Alcohol and youth, attitudes and values, trigger film.
Details: 16 mm, 13 min, color.
Synopsis: Two girls and two boys sneak into an abandoned building to meet Shelly who is bringing some beer. Shelly is late and the children begin to think about their day. Flashbacks show incidents in each child's life. One girl has been urged by her parents to go out with friends more and not read so much — however, she is not sure that drinking in an abandoned building is what her parents had in mind. The other girl's mother is a problem drinker and this interferes with their home life; she has vowed never to be like her mother. Both boys also recall incidents. Shelly shows up with the beer and each child has to decide whether or not to stay.
General evaluation: Good to very good (4.6). This contemporary, well-produced film was judged a good teaching aid.
Recommended use: With a resource person to lead the discussion, this film could benefit audiences 12 to 15 years.

Prescription for a Professional

Number: 578.
Subject Heading: Employee assistance programs.
Details: 16 min, videotape.
Synopsis: A group of clinic doctors gather for a staff meeting. At the end of the meeting one decides to bring up a problem that he has been thinking about all day. A fellow doctor has been lax in his duties —not seeing his patients on time and frequently not being in the clinic to attend his patients. Some staff recommend that his services be terminated, but one believes that he can be helped. Slowly, the others come to see that perhaps they have a responsibility to help him by referral to the physicians' aid committee.
General evaluation: Poor to fair (2.7). Although the message in this film was appropriate, the exclusive use of slides in a videotape format detracted from the presentation.
Recommended use: For training of physicians in employee assistance programs.

The Party

Number: 579.
Subject heading: Alcohol and youth, trigger film.
Details: 6 min, color.
Synopsis: This trigger film is part of a series entitled "Pickles and Jams and How To Get Out of Them." Two young boys are playing in a park while waiting for two other friends. When they arrive one of the boys invites them all to his house, where his older brother is having a party with live music. The boys want to go, but when one wants to let his mother know where he will be, he is asked not to do so since the party is unsupervised and alcohol and other drugs are being used. Now the boys have to decide what to do.
General evaluation: Good to very good (4.8). This contemporary, well-produced film is an excellent teaching aid that could lead to good discussion.
Recommended use: With a resource person to lead the discussion, this film could benefit audiences eight to 12 years.

Trying Times

Number: 580.
Subject heading: Smoking, alcohol and youth, attitudes and values.
Details: 18 min, color.
Synopsis: Meg is visiting her cousin Julie in the city. Julie has started to smoke and convinces Meg that she should also learn so that Julie's friends will accept her. They practise in front of a mirror. Julie's parents go out for the evening and Julie says they will stay in and watch television. However, as soon as her parents leave, Julie takes Meg to the woods to meet her friends who are drinking and smoking. The police come and the young people scatter leaving Meg alone to run terrified back through the woods to Julie's house. Julie tells a distraught Meg that next time it will be even more fun.
General evaluation: Good (4.2). This well-produced videotape could lead to good discussion about making decisions regarding cigarettes and alcohol.
Recommended use: With a resource person to lead the discussion, this film could be beneficial to young people between 12 and 15 years.

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DEPARTMENT

New Books by RON HALL

Clinical Management of Poisoning and Drug Overdose

. . . edited by Lester M. Haddad and James F. Winchester

The first part of this text gives a general approach to the toxicologic patient. Chapter one presents a summary approach of the basic emergency management of poisoning and also serves as an outline to the material that is presented in detail throughout the succeeding 15 chapters of this first part. The second part addresses the management of specific agents. Each chapter has been cross-referenced to other chapters and sections throughout the book, and this is followed by a comprehensive index. Chapters in the first part include, among others: principles of pharmacology for the clinician, central nervous system disturbances, cardiac disturbances, acid-base disorders, brain death, and principles of respiratory therapy. The second part dealing with specific poisons focuses on natural and environmental toxins, centrally active agents, analgesics, pesticides, metals and inorganic agents, solvents, cardiovascular agents, and antimicrobials.

(W. B. Saunders Company, 1 Goldthorne Ave, Toronto, ON M8Z 5T9. 1983. 1,012p. $97.50. ISBN 0-7216-4447-3)

Forbidden Highs

. . . by Reginald G. Smart

The areas covered in this book are of most interest to people seeking information on the nature, treatment, and prevention of illicit drug abuse. The emphasis is on studies and experience from Canada and is intended for those concerned with drug problems, especially concerned citizens, professionals new to the field, students who want to learn more about drugs, and drug researchers. The author presents a historical perspective on drug use in Canada followed by a discussion of the nature and extent of drug use and abuse. A section devoted to prevention and control covers national laws and their preventive effect, Canadian and international drug laws, socioculture contexts and drug use in Canada and the United States, drug education, the role of parents, and treatment of drug abuse. The volume concludes with a chapter on the future of illicit drug use and its prevention. Illustrations and references are included.

(Addiction Research Foundation, Marketing Services, 33 Russell St, Toronto, ON M5S 2S1. 1983. 244p. $12.95. ISBN 0-88868-078-3)

Report of the International Working Group on the Single Convention on Narcotic Drugs, 1961

. . . prepared by Reginald G. Smart, Glenn F. Murray and H. David Archibald

In association with the World Health Organization and the International Council on Alcohol and Addictions, the Addiction Research Foundation convened a meeting of international experts in September 1982 to examine how the objectives of the Convention could be met and then moved on to a general discussion of what should be expected from international drug treaties. Recommendations were aimed at improving the treaty and international drug control efforts in general. This Report on the Single Convention was presented to the United Nations Commission on Narcotic Drugs in February 1983. The major sections of this report, published in English, French, and Spanish are: controversial issues concerning the effects and effectiveness of the Single Convention, benefits of the Convention, problems, and conclusions and recommendations.

(Addiction Research Foundation, Marketing Services, 33 Russell St, Toronto, ON M5S 2S1. 1983. 66p. $4.50. ISBN 0-88868-077-5)

Other books

The Encyclopedia of Alcoholism — O'Brien, Robert and Chafetz, Morris. Facts on File Publications, New York, 1982. History of alcohol and man: dictionary format covering alcohol abuse. Bibliography, index. 378 p. Facts on File Publications, 460 Park Ave S, NY, NY 10016. $40. ISBN 0-87196-623-9.

Incest in the Organizational Family: The Unspoken Issue in Staff and Program Burn-Out — White, William L. HCS, Inc, Potomac, 1978. Systems approach to staff burn-out; open vs closed organizational families; incest in the closed organizational family; detachment and isolation in the open organizational family. 47 p. HCS, Inc, 11325 Seven Locks Rd, Ste 231, Potomac, MD 20854. $5.

Relapse as a Phenomenon of Staff Burn-Out Among Recovering Substance Abusers — White, William L. HCS, Inc, Potomac, 1978. Understanding staff burn-out; case histories; role stressors associated with relapse of recovering substance abusers working in a substance abuse field. References. 53 p. HCS, Inc, 11325 Seven Locks Rd, Ste 231, Potomac, MD 20854. $5.

A Systems Response to Staff Burnout — White, William L. HCS, Inc, Potomac, 1978. Micro-systems response to staff burn-out; burn-out casualties; macro-system response to staff burn-out. References, bibliography. 46 p. HCS, Inc, 11325 Seven Locks Rd, Ste 231, Potomac, MD 20854. $5.

The Strange Career of Marijuana: Politics and Ideology of Drug Control in America — Himmelstein, Jerome L. Greenwood Press, Westport, 1983. Changes in marijuana laws; examination of existing explanations of laws; changes in the image of marijuana in public discussion; arguments against harsh penalties for marijuana use. Bibliography; index. 179 p. Greenwood Press, 88 Post Rd W, PO Box 5007, Westport, CT 06881. $27.95. ISBN 0-313-23517-1.

Another Chance: Hope and Health for the Alcoholic Family — Wegscheider, Sharon. Science and Behavior Books, Palo Alto, 1981. Conceptual frame; shared disease; family roles; treatment plan. Index. 256 p. Science and Behavior Books, 701 Welch Rd, Palo Alto, CA 94306, $12.95. ISBN 0-8314-0059-5.

Statistics on Alcohol and Drug Use in Canada and Other Countries — Addiction Research Foundation, Toronto, 1983. Highlights of alcohol and drug use; alcohol — consumption, health, crime and traffic accidents, economics; narcotics and other drugs — student drug use, adult drug use, health; tobacco; caffeine; international alcohol statistics; technical notes. Index. 324 p. Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1. $23.50. ISBN 0-88868-076-7.

Alcohol and Youth — Jeanneret, O. (ed). S. Karger AG, Basel, 1983. Biomedical aspects; psycho-social aspects; legal and forensic aspects; perspectives; selective bibliography. Index. 211p. S. Karger AG, PO Box CH-4009, Basel, Switzerland. $56.50. ISBN 3-8055-3655-0

Alcoholism: Treatable Illness — Strachan, J. George. Hazelden Foundation, Center City, 1982. Nature and magnitude of the illness; illness concept; treating the illness. Index. 310p. Hazelden Foundation, Box 176, Center City, MN 55012. $12.95. ISBN 0-89486-149-2

Drugs and Sex: A Bibliography — Abel, Ernest L. Greenwood Press, Westport, 1983. 1,432 citations related to drugs and sex. Index. 129p. Greenwood Press, 88 Post Rd W, PO Box 5007, Westport, CT 06881. $29.95. ISBN 0-313-23941-X

The Ladykillers: Why Women Smoke — Jacobson, Bobbie. Eden Press, Montreal, 1983. Sexual politics of smoking; self-help; coping. 135p. Eden Press, 4626 St Catherine St, Montreal, Quebec H3Z 1S3. $6.95. ISBN 0-920792-21-9

This publication is indexed in BIHEP BIBLIOGRAPHIC INDEX OF HEALTH EDUCATION PERIODICALS

DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Behavioral Interventions Course — Nov 14-16, Toronto, Ontario. Information: Doreen Ross, Addiction Research Foundation (ARF), School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Detox Training Program (Non Medical) — Nov 14-18, Toronto, Ontario. Information: Diane Hobbs, Detox and Rehab Programs, ARF, 33 Russell St, Toronto, ON M5S 2S1.

Strategies for Coordinating Community Services Workshop — Nov 21-23, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Controversies in Clinical Trials; A Workshop and Symposium for Government, Academia, and the Pharmaceutical Industry — Dec 1-2, Montreal, Quebec. Information: Clinical Symposium Associates, 63 Skyline Dr, Dundas, Ontario, L9H 3S3.

Group Therapy Course — Jan 9-13, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Fundamental Concepts Course in Addictions — Jan 16-19, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Perspectives on Employee Assistance Programming Course — Jan 23-26, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Annual Meeting of the Ontario Psychiatric Association — Jan 26-28, 1984, Toronto, Ontario. Information: Donna Gray, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Pharmacology and Drug Abuse Course — Feb 6-8, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

1984 Professional Practice Conference — Feb 6-8, 1984, Toronto, Ontario. Information: Canadian Society of Hospital Pharmacists, Ste 303, 123 Edward St, Toronto, ON M5G 1E2.

37th Annual Convention of the Ontario Psychological Association — Feb 9-11, 1984, Toronto, Ontario. Information: Pierre Ritchie, Convenor, OPA '84, 1407 Yonge St, Ste 402, Toronto, ON M4T 1Y7.

National Joint Conference on Nursing Education and Practice — Feb 9-12, 1984, Ottawa, Ontario. Information: Jocelyne Robert-Tanguay, Conference Coordinator, Canadian Nurses Association, 50 The Driveway, Ottawa, ON K2P 1E2.

Prevention Strategies Workshop — Feb 20-22, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Workshops 1983-84: Employee Assistance Program Management Update — Feb 22-24, 1984, Toronto, Ontario. Information: Yvonne Johns, department head, department of Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Circuit and Rural Court Justice in the North — March 11-16, 1984, Yellowknife, Northwest Territories. Information: The Northern Conference, c/o Continuing Studies, Simon Fraser University, Burnaby, British Columbia V5A 1S6.

1984 Canadian Addictions Foundation Atlantic Regional Conference, Families and Drug Dependencies New Problems, New Challenges — Apr 29-May 3, 1984, Halifax, Nova Scotia. Information: Nova Scotia Commission on Drug Dependency, 5668 South St, Halifax, NS B3J 1A6.

Introductory Addictions Management Course — May 14-16, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Summer Fundamental Concepts Course — July 16-19, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: Mr J. Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

Adolescents and Alcoholism and Other Drug Dependencies — Nov 3-4, San Francisco, California, Nov 28-29, Houston, Texas. Information: Joanne Terry, Johnson Institute, 10700 Olson Hwy, Minneapolis, Minnesota 55441-6199.

National Conference on Medical Education and Research in Alcobol and Drug Abuse — Nov 10-11, Washington, DC. Information: AMERSA, Career Teacher Center, Downstate Medical Center, 450 Clarkson Ave, Box 129, Brooklyn, New York 11203.

Seminar on Chemical Dependency and Family Recovery — Nov 14-18, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

Issues of Sexuality in Alcohol/Drug Dependency Counselling — Nov 17-19, Center City, Minnesota. Information: Marilyn Brissett, Continuing Education department, Hazelden Foundation, Center City, MN 55012.

Recent Developments in the Treatment of Disturbed Adolescents — Nov 18, New Hyde Park, New York. Information: Ann Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

Communications and Marketing Conference for Professionals, Treatment Programs and Volunteer Organizations — Nov 18-19, San Diego, California. Information: Marcon West, 2100 N 105th, Seattle, Washington, 98133.

2nd Annual National Conference on Alcoholism and the Family, Western Edition — Nov 20-23, San Diego, California. Information: FamCon West II, PO Box C 19051, Seattle, Washington 98109.

Family Program for Professionals — Nov 28-Dec 2, Center City, Minnesota. Information: Marilyn Brissett, Continuing Education department, Hazelden Foundation, Center City, MN 55012.

Intervening with Alcoholic and Other Drug Dependent Families — Nov 29-Dec 2, Orlando, Florida. Information: Joanne Terry, Johnson Institute, 10700 Olson Hwy, Minneapolis, Minnesota 55441-6199.

Toughlove Action Training for Professionals Working with Young People — Nov 30, Philadelphia, Pennsylvania. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, PA 18960.

The 3rd Annual New England Conference on Alcohol Issues, "Trends in Policy and Planning for Alcohol Issues" — Nov 30-Dec 2, Newport, Rhode Island. Information: New England Conference on Alcohol Issues, 755 Boylston, Ste 306, Boston, Massachusetts 02116.

SECAD/8, Southeastern Conference on Alcohol and Drug Abuse — Nov 30-Dec 4, Atlanta, Georgia. Information: Barbara D. Turner, Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, Georgia 30342.

Marketing Your Program (Without Spending a Fortune) — Dec 1-2, San Francisco, California. Information: Kim Farthing, Program Coordinator, National Association of Alcoholism Treatment Programs, Inc, 2082 Michelson Dr, Ste 200, Irvine, CA 92715.

Group Facilitator Skills — Dec 5-9, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee, WI 53221.

Chemical Dependency Counseling Skills — Dec 5-9, Minneapolis, Minnesota. Information: Jan Winsand, Johnson Institute, 10700 Olson Hwy, Minneapolis, MN 55441-6199.

Toughlove Action Training for Professionals Working With Young People — Dec 7, Framingham, Massachusetts. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania 18960.

Alcoholism and Drug Abuse: Problems in Clinical Decision-Making — Dec 7-10, New York, NY. Information: Elizabeth C. Gerst, Continuing Education Center, 630 West 168th St, New York, NY 10032.

Alcoholism — The Search for the Sources — Jan 18-20, 1984, Charlotte, North Carolina. Information: Elaine Woody, Center for Alcohol Studies, School of Medicine, University of North Carolina at Chapel Hill, 335 Medical School Building, 207H, Chapell Hill, NC 27514.

Toughlove Weekend Workshop for Parents and Professionals — Jan 28-29, 1984, Baltimore, Maryland. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania 18960.

5th Training Institute on Addictions — Feb 2-7, 1984, Clearwater Beach, Florida. Information: The Institute for Integral Development, PO Box 2172-T, Colorado Springs, CO 80901.

International PRIDE Conference for Adults and Youth — March 22-24, 1984, Atlanta, Georgia. Information: PRIDE, 100 Edgewood Ave, Ste 1216, Atlanta, GA 30303.

Toughlove Weekend Workshop for Parents and Professionals — March 24-25, 1984, New Brunswick, New Jersey. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania, 18960.

Health and Addictions Seminar — March 25-30, 1984, Park City, Utah. Information: The Institute for Integral Development, PO Box 2172-T, Colorado Springs, CO 80901.

Sexuality and Alcohol/Drug Dependence — March 26-28, 1984, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Ruth Fox Course for Physicians — April 12, 1984, Detroit, Michigan. Information: Claire Osman, Course Coordinator, American Medical Society on Alcoholism, 733 3rd Ave, New York, NY 10017.

National Alcobolism Forum of the National Council on Alcoholism — April 12-15, 1984, Detroit, Michigan. Information: Angela Masters, 733 3rd Ave, New York, NY 10017.

15th Annual Medical-Scientific Conference of the National Alcoholism Forum, "Clinical Applications of Alcoholism Research" — April 12-15, 1984, Detroit, Michigan. Information: Medical-Scientific Conference Coordinator, AMSA, 733 3rd Ave, 14th fl, New York, NY 10017.

Introduction to Alcohol/Drug Counseling — April 25-27, 1984, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

46th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 4-6, 1984, St Louis, Missouri. Information: Joseph Cochin, department of Pharmacology, Boston University, School of Medicine, 80 E Concord St, Boston, Massachusetts 02118.

Abroad

Currents in Alcohol Research and the Prevention of Alcohol Problems — Nov 7-9, Lausanne, Switzerland. Information: Beat Lehner, Redaktor, Schweizerische Fachstelle Fuer Alkoholprobleme, Case postale 1063, 1001 Lausanne, Switzerland.

2nd Pan Pacific Conference on Drugs and Alcohol — Nov 27-Dec 3, Hong Kong. Information: Conference Secretary, 2nd Pan Pacific Conference on Drugs and Alcohol, c/o Hong Kong Council of Social Service, GPO Box 474, Hong Kong.

2nd International Congress on Drugs and Alcohol — Dec 18-22, Tel Aviv, Israel. Information: Congress Secretariat: Peltours Ltd, Congress department, PO Box 394, Tel Aviv, 61003 Israel.

An International Conference on Alcoholism and Drug Addiction — Apr 2-7, 1984, Canterbury, England. Information: Conference Secretary, Broadway Lodge, Oldmixon Rd, Weston-super-Mare, Avon, BS24 9NN, England.

30th International Institute on the Prevention and Treatment of Alcoholism — Athens, Greece, May 27-June 2, 1984. Information: International Council on Alcohol and Addictions, Case postale 140, 1001 Lausanne, Switzerland.

4th World Congress of Alternative Medicine — July 13-15, 1984, Amsterdam, Netherlands. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: Dr H. D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

Apathy, ambivalence prevail

Israel's anti-smoke battle in its infancy

By Terry Brodie

TEL AVIV — A 30-year-old woman with asthma and allergies recently visited a Kupat Holim (Sick Fund) clinic here. If she was hoping to get help for her breathing problems, she went to the wrong place: the physician filling out the woman's chart was puffing heavily on a cigarette.

A United States student at Tel Aviv University's Sackler School of Medicine had barely arrived in Israel when he suffered a spontaneous lung puncture and was rushed to hospital. As the student was wheeled to the emergency operating room, the doctor running alongside him had a lighted cigarette dangling from his mouth.

While that kind of behavior might raise eyebrows elsewhere, an Israeli would hardly flinch. For it is evident not only in hospital corridors, but also in offices, movie theatres, buses, restaurants, and the living rooms of homes throughout Israel. Smoking is an accepted habit — and few seem to be aware of or care very much about its hazards.

Valiant effort

While Israel's Knesset (parliament) earlier this year passed a much-debated law to limit cigarette advertising (**The Journal**, March), and a small group of Western immigrants has recently been making a valiant effort to promote the rights of non-smokers, the battle here against smoking has hardly begun. Indeed, the anti-smoking militancy that has swept the West like a hurricane has barely stirred a breeze in this tiny nation. Legal and social inhibitions of smoking are few.

And so smokers are a pervasive and triumphant lot, lighting up at will, blowing smoke freely into unreceptive faces, and butting cigarettes wherever they fall.

The latest Health Ministry figures show about 37% of all adult Israelis smoke, a statistic that compares to the smoking rate in most western countries. Also similar to patterns abroad, the number of men who smoke has dropped to 40% in 1980 from 51% in 1970, while the number of female smokers steadily climbs — up to 30% in 1970 and 34% today from 13% in 1958.

Israelis, however, smoke more heavily than their foreign counterparts — about a third go through more than 20 cigarettes, or one package, a day.

Big business

Cigarettes are a big and stable business in Israel. They are manufactured by three companies — the smaller two owned by West Bank Arabs — and several foreign labels are imported. By far the biggest producer, however, is the Dubek Corporation, which turns out 19 brands of cigarettes and enjoys a virtual monopoly of 82% of the smokers' market. Dubek's managing director, Zorach Gehl, says nearly 7½ billion cigarettes (local and imported) are smoked in Israel every year, with total sales amounting to about $164 million (US).

About 3,000 Israelis are considered likely to die this year of diseases linked to the habit. Nevertheless, a gathering of Israelis is inevitably clouded by smoke.

Says Tuvia Lehrer, PhD, deputy director of the Health Ministry's health and education department, and an adviser on smoking to the Israel Cancer Association: "Until now, it is an accepted social norm to smoke here, so when you gather, there are smokers all around you. But that is really different in the United States and other countries, where the norm is not to smoke and so, in public, people smoke less."

Young Israelis: a good half leave their three-year army service addicted

While laws banning smoking on local buses and in movie theatres exist, and other regulations specify permitted smoking areas on inter-city buses and in hospitals and medical clinics, few Israelis abide by them: a bus driver can hardly force a passenger to extinguish a cigarette when he's got one burning, and a doctor cannot chide a patient for ruining his health between his own puffs of smoke.

Nor do Israelis seem to care about violating these laws. A study by the Applied Social Research Institute in Jerusalem showed that only about a third of all adult Israelis had ever asked someone to butt-out in a public place, even though some 60% — and 71% of non-smokers — said they were bothered by the smoking. The main reason they gave for not acting was apathy.

Education cursory

Education about the effects of smoking gets a cursory effort, at best. Not one school in the country, says Dr Lehrer, devotes any regular programming to smoking and its effects. Principals, given leeway in planning a quarter of the school curriculum, may include the topic, and representatives from the Israel Cancer Association and the health ministry, and some private physicians have offered to give free lectures. But fewer than half of all principals have used them, even as a one-time gesture, says Dr Lehrer.

When the lectures are delivered, the students are already in their teens. "The basic education is all wrong," insists Dr Jan Kellerman, head of the cardiac care unit at the government-run Tel Hashomer Hospital. "If you start in childhood, you can succeed in educating children about the preservation of health, not just the prevention of disease. It has to start young."

Tense situations

The army is no better. Its young recruits are not offered any kind of programming to warn about the habit, either. In fact, reports Dr Lehrer, while some 30% of Israel's youth smoke at least sometimes before entering the army, at least half leave their three-year service with the habit in tow. Even more disturbing, he adds, is the fact that virtually all young female smokers form the habit while in uniform.

Dr Lehrer also insists the assumption that the tensions of living in Israel society foster smoking is a misconception. "Those people who really live in tense situations, like the generals and high officers in the army, actually smoke less than others," he notes, citing a study done during the 1973 Yom Kippur War which found fewer smokers among front-line soldiers than among civilians.

For smokers who want to kick the habit, there are few places to turn for help. Just over a decade ago, Dr Lehrer (a two-pack-a-day smoker who quit and then wrote a book on how to do it) founded the Israel Society for the Prevention of Smoking. It ran smoking-cessation groups. The organization folded in late 1977 for lack of funds, and the Israel Cancer Association (ICA) picked up where it left off. Today, it's the only organization running regular quit-smoking groups.

Medical reasons

In the past 11 years, says Dr Lehrer, some 7,000 Israelis have passed through sessions offered by both organizations. Just over a third of the course's graduates, says Aviva Karev of the ICA, never go back to the habit. That is a much higher figure than the 12% who manage to kick smoking in the US, she adds.

Yet, it appears more Israelis would like to quit: another health ministry study two years ago found that some 71% of Israeli smokers tried to quit at some point in their lives, nearly 62% of them within the last year. But while North Americans would like to be coddled into quitting, Israelis would rather tackle the challenge alone; some 64% of the study's respondents said they didn't want any help.

Dr Lehrer adds almost all Israelis who attend quit-smoking sessions only sign up when they have immediate medical reasons for cutting cigarettes out of their lives.

Yet, however embryonic, the effort to curb smoking is there. And its supporters, largely North American immigrants, hope to put to the test some of the anti-smoking militancy they learned back home.

A few members of the Association of Americans and Canadians in Israel (AACI) in Jerusalem recently banded together under the AACI's quality of life committee to form a subcommittee dedicated to promoting non-smokers' rights.

Says the subcommittee's chairman, Dr Sabrina Cohen, who runs health education for the city of Jerusalem's public health services department: "We hope to enforce the non-smokers' rights that exist and get non-smokers to be more assertive."

Earlier this year, the subcommittee dispatched a group of high school students to bus stops throughout the capital to hand out flyers explaining the laws governing smoking. It also set up a table, packed with information on smoking, outside the central Hamashbir department store. The group has also enlisted the police in its campaign: officers will soon board buses, at random, to hand out tickets to offenders of the current laws.

"When I ask people politely to stop, they respond," observes Dr Cohen. "It's just a matter of creating the atmosphere that smoking is not acceptable. People have to wake up to the facts."

Ads restricted

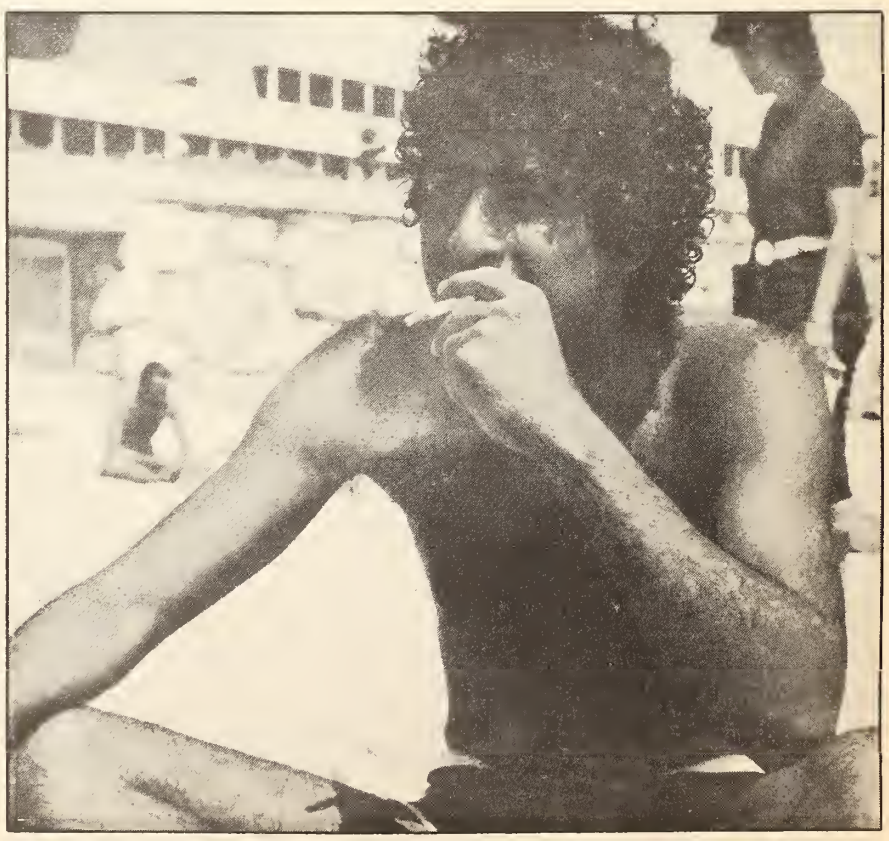
The new Knesset law also puts severe restrictions on cigarette advertising. All cigarette ads are now banned from radio, television, cinemas, and other public screens, such as billboards and bus displays. The ads are permitted in newspapers and magazines, as long as they depict only the cigarette packages, with no words of praise for the habit or enticing images. In addition, cigarette packages and ads now carry the warning: "The Ministry of Health has determined that smoking is harmful to health."

Still to come is another bill, introduced by Knesset Member Akiva Nof, that would limit smoking in public places. But that bill is still at committee level, and its supporters predict it will be a long while before it passes into law.

But it will take more than laws to curb smoking in Israel.

"There must be an education campaign to inform people here about the need to keep the laws," says Dr Lehrer. "Right now, too many people have the feeling that the police and the law are not that important. You can't enforce laws or change behavior with that attitude."

Meanwhile, Israel's smokers will continue to light up.



An accepted habit: not only at the beach but also in hospital corridors

THE BACK PAGE

AIDS . . . a medical mystery story

By Gary Lamphier

TORONTO — It has been called the 'gay plague.' Yet, one in four affected by it is heterosexual, and its appearance remains statistically uncommon except in a few large United States cities.

Wherever the syndrome appears, fear and suspicion follow. But much that has been said or written about it is based on speculation. Misinformation has bred irrational fear and, worse still, abuse of those who are its victims.

Item: United Press International reports that a Florida hospital spent $7,000 on a rented Lear jet to rid itself of a patient who had the syndrome. The hospital flew the man, against his will, to California.

Item: In the midst of growing panic, the United States National Hemophilia Association called for a ban on blood donations from gay men.

Item: A Victoria psychiatrist, writing in the *British Columbia Medical Journal*, suggested homosexuals "get back to the closet," since their "dangerous unnatural practices" had "propogate(d) a disease that can wipe out all of society."

The subject that has caused such alarm, and generated so much fear, is Acquired Immune Deficiency Syndrome, or AIDS. Not since Legionnaire's Disease have the media and the public been so riveted by a medical mystery story.

The first known cases of AIDS appeared in 1979 in Europe. In 1981, the syndrome surfaced in the US. Since then, it has primarily expressed itself in four groups deemed to be at risk: homosexual and bisexual males with multiple sexual partners; intravenous (IV) drug abusers (17% of all US cases, though the figure is closer to 27% if one considers IV drug use as a secondary factor among other risk groups); Haitians; and hemophiliacs.

The Atlanta-based Centers for Disease Control (CDC) confirms that approximately 94% of the 2,513 AIDS cases identified in the US through Oct 24 occurred among these groups, including 1,805 (71%) among homosexual and bisexual men.

Of the remainder, several are believed to have contracted AIDS through sexual contact with a partner who has AIDS, or through blood transfusion. Insufficient data leave other cases unexplained.

Whatever the source of infection, the mortality rate among those who have AIDS appears to be high. About 42% (1,048) of the US cases and 51% (23) of the Canadian cases identified to date have ended in death.

But AIDS alone doesn't cause death. Rather, death can follow from the "opportunistic infections" that develop in its wake.

The Ontario Disease Surveillance Report, published by the province's ministry of health, defined AIDS in its Sept 2 issue as "a reliably diagnosed disease, at least moderately indicative of underlying cellular immune deficiency, occurring in a person who has had no known underlying cause of cellular immune deficiency, nor any other cause of reduced resistance reported to be associated with that disease."

The report goes on to say opportunistic infections include "certain protozoal and helminthic infections, fungus infections, mycobacterial infections, viral infections, as well as Kaposi's Sarcoma (KS) and brain lymphona."

Figures in the US show the most common infection to be Pneumocystis carinii pneumonia (PCP). The same issue of the surveillance report says 51% of US AIDS patients have PCP, 26% have KS (a rare cancer found mostly in elderly men of Eastern European or Mediterranean origin), 8% have both PCP and KS, and 15% have other opportunistic infections. Generally, IV drug abusers are more likely to contract PCP; homosexuals and bisexuals more frequently get KS, researchers say.

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Holiday Greetings

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Industries need clear drug policy

WASHINGTON — The mellow fruit of the 60s is rotting. Now what do we do about it in the 80s?"

This question is a major one for industry and must be handled by clear, stated policies on drugs, says Lee Dogoloff, executive director of the American Council on Drug Education.

There are three essentials, he told a council-sponsored conference on drugs in industry:

- Expectations of behavior by employees must be made clear and unequivocable.
- Sanctions and penalties must be spelled out for those who violate a clearly stated policy.
- Policy on drug use must be enforced.

Drugs in the workplace p 2

Robert Diegelman, executive director of Performance Diagnostics, a consulting firm here, said it is estimated alcohol and drug use costs United States industry up to $60 billion a year.

A study of one major corporation found employees with drug problems work more slowly, make more mistakes, are repeatedly involved in grievance proceedings, and are credited with 50% of problems in production.

Provincial commissioners undecided on joint action

Cdn chiefs debate national alliance

By Karin Maltby

TORONTO — Chairmen of alcohol and drug commissions across Canada are considering forming a national body. At the same time, they are deliberating whether the Canadian Addictions Foundation (CAF) should be the national voice most chairmen agree is necessary.

Chairmen from seven Canadian jurisdictions met formally for the first time in Victoria, British Columbia, in October at the invitation of John Gogo, chairman of the Alberta Alcohol and Drug Abuse Commission (AADAC).

Mr Gogo told **The Journal** the chairmen deliberated for 2½ days on issues ranging from drunk driving to a 'dedicated tax' on alcohol (**The Journal**, Nov).

They also discussed the feasibility of a national coalition and the role of the CAF.

It isn't certain whether the chairmen will meet formally again. However, Les Stoodley, chairman of the Nova Scotia Commission on Drug Dependency, has invited them to convene again in Halifax next spring.

Meanwhile, chairmen of the four Atlantic provinces' commissions were scheduled to meet separately at the end of last month to discuss the possibility of forming an Atlantic coalition to represent New Brunswick, Newfoundland, Nova Scotia, and Prince Edward Island.

Mr Gogo said he has some reservations about chairmen forming a national group. "I think there should be a national voice, and, so far, the CAF is that national voice."

(The CAF is an agency representing professionals and lay people in the addictions field. Mr Gogo, through the AADAC, was instrumental in relocating the financially-troubled agency from Ottawa to offices provided by the AADAC in Edmonton, and in securing some financial help for it — **The Journal**, Aug 82).

Gogo: a national voice

Mr Gogo: "I do have some concerns about chairmen coming out with national statements. There's no doubt in my mind there's got to be a national voice — I'm not so confident I want them to be the national voice."

A Member of the Legislative Assembly (MLA) in Alberta, Mr Gogo concedes his dual role as both chairman and an MLA could lend power to a national coalition, but "that's a two-edged sword.

"I could take a position as a politician based on my constituency. I think many here think the drinking age should be 21 (it is 18 years in Alberta) . . . Yet, if I'm not careful, the repercussions of any actions that I precipitate could go to the AADAC, so I've got to be somewhat cautious that AADAC doesn't become penalized in the process for actions by its chairman."

John B. Macdonald, PhD, chairman of the board of the Addiction Research Foundation of Ontario, told **The Journal** he sees value in the chairmen meeting occasionally for an exchange of information, "and really I see that as the primary value."

He continued: "I don't think it's likely, as a formal body, that chairmen will be in a position to take collective actions. Priorities, programs, and developments in different provinces are in many cases quite different; chairmen play different roles.

"In Ontario, the chairman and the members (of the board) function as a board of directors, and the chairman is not in a position to speak for them."

Eve Beck, chairman of the Alcohol and Drug Dependency Commission of Newfoundland and Labrador, is one of the chief supporters of the idea of a coalition (**The Journal**, Oct).

However, she told **The Journal** "there was a feeling among the chairmen that we're not ready for a coalition yet."

She told the Victoria group consensus should not be the aim. Rather, "I think the important part is airing our concerns and our views and knowing how our colleagues feel across the country."

(See — Provincial — p 2)

Drugs playing havoc with world economy

By Behrouz Shahandeh

OSLO — Illicit revenues from drug trafficking are estimated to be "larger than the bill for all legal drugs sold to cure all the diseases man is heir to," says the senior scientific advisor, Intergovernmental and International Affairs, Health and Welfare Canada.

Donald M. Smith, PhD, also former chairman of the United Nations Commission on Narcotic Drugs, told the 13th International Institute on the Prevention and Treatment of Drug Dependence here that such large-scale and wide-ranging illegal drug sales are playing havoc with the world economy and undermining the well-being of the people.

Dr Smith continued: "Enslavement to drugs deprives this society of the most valuable contribution the individual can make, that of an intelligent, fully-functioning human being in full possession of his or her faculties, motivated and able to engage in the complex tasks required in modern technological societies."

He said this incapacity of members of a society leads to numerous indirect economic effects. Costs to the justice and enforcement systems and the health and welfare services are only the apparent and quantifiable expenses.

There are also the "possibilities of corruption not only in the justice system but also of whole segments of the economy in communities where an illegal way of life becomes the main source of income.

"This can even extend to whole nation-states where a major factor in favorable trade balances may well be the income from the illicit traffic and the production of illicit drugs.

"The other side of this economic coin is the negative effect on the balance of payments in countries where there are a large number of addicts creating a demand for imported illegal drugs — leading to the siphoning of the proceeds of the illicit traffic into the hands of organized criminals and other anti-social groups such as terrorists.

"World-wide totals of the order of hundreds of billions of dollars have been estimated," he said.

INSIDE

NEWS

Briefly...

Morning-after drivers

CHICAGO — A Swedish study suggests hangovers may impair driving ability by as much as 20%, even after the blood alcohol level returns to zero. The study, by the Swedish Road and Traffic Research Institute, was reported in the *Journal of the American Medical Association*. It said impairment may continue for as long as three hours. Six women and 16 men were put through a driving obstacle course in the morning, following a night of wining and dining and an overnight stay in the laboratory.

Heart drug finding

LONDON — British researchers have discovered that propranolol, a widely prescribed heart drug, may also be an effective birth control agent. A vaginal suppository containing the beta-blocker stopped sperm from reaching the egg, reports Paul Turner, a clinical pharmacologist at St Bartholomew's Hospital here, in a Toronto *Globe and Mail* article. Tests showed propranolol to be a powerful inhibitor of sperm movement.

China's beer cure

PEKING — A Chinese brewery is now making the startling claim that its beer can prevent cancer. An advertisement in the *China Daily Star* says Arctic Ocean and White Snow beers are "nutritious, stop thirst, good for the digestive system, can increase blood circulation, and prevent cancer." The ad suggests the reader should drink these beers, "to make you happy and well for the rest of your life."

Teachers set example

LONDON — Teachers ought to be told on recruitment that they will not be allowed to smoke on school premises, says Charles Fletcher, president of ASH (Action on Smoking and Health.) He says evidence shows smoking in schools is higher when teachers smoke, and he partly blames teachers for the fact one quarter of Britain's school children are regular smokers by the time they reach the fifth form (age 16).

Valium use down

WASHINGTON — Use of Valium (diazepam) in the United States has declined to 25 million prescriptions per year from a peak of 61 million prescriptions in the mid-1970s. Reasons given by Roche Laboratories, makers of the drug, are competition from other benzodiazepines on the market, negative publicity about possible dependence, and "bad jokes about the drug which have caused people to shy away from it," reports *USA Today*. The US Pharmaceutical Manufacturer's Association reports that since 1976 prescriptions for all tranquillizers have dropped by 30%.

Prescription safety

LONDON — A new code of ethics suggested by a working party of Britain's Pharmaceutical Society advises pharmacists not to dispense prescriptions — even after checking with the prescriber — if they have doubts about the safety of the product. The code also forbids substitution of drugs on a prescription, says a report in *Doctor*.

Industry should stress safety, not cost

Risk reduction is key to drug policy

By Harvey McConnell

WASHINGTON — Safety, not cost, should be the cornerstone of any company drug and alcohol policy.

"It is no good having a policy unless it comes within the framework of health and safety," advises Peter Bensinger, head of a private consulting firm in Chicago and former director of the United States Drug Enforcement Administration.

The first line supervisor is the one who counts, he told a conference here on drugs in industry sponsored by the American Council on Drug Education. "You can have all the numbers and all the statistics you want, but they are not going to convince the first line supervisor, who can make a difference at the workplace.

"The key to a good alcohol and drug abuse policy is risk sensitive rather than cost sensitive."

Emphasis should be on risks to safety, risk of loss of life, risk of hurting the company's reputation, risk of arrest of employees on and off the job, risk of embarassing a potential client, and risk to security, both national and company, including trade secrets and patents.

Mr Bensinger said today's typical first line supervisor "didn't go to high school in the late 1960s, doesn't understand 'druggies,' and probably doesn't feel comfortable around drug users or people who have a different perspective. He is unlikely to involve himself, or intervene, and intervention

Bensinger: dealing drugs, data

is the name of the game.

"And if the first line supervisor won't act, the senior and top management don't know, and the employees and peers who do know won't talk. You have to bring the message of risk to all of these people, that the co-worker is the one at risk, not the addict."

A recent example, he said, is an airline mechanic, later found to have a history of marijuana use, who displayed the short-term memory loss caused by the drug by forgetting to refuel a passenger jet. The plane came close to crashing as pilots executed an emergency landing.

In some fields, the obvious person is not necessarily the only person to worry about.

Mr Bensinger: "Let's not only think about the crane operator swinging the big steel up on a construction site. Who is rigging the load? If the rigger is on drugs, the load will fall anyway no matter how good the crane operator."

Security is a major risk. "People can start a cocaine habit on a paycheck, but they can't sustain it. They are then going into stealing, selling, and dealing — not just in drugs but in data."

Companies must make their security rules plain and then enforce them. "If the rule is that everybody is subject to search, and you don't search, then you don't have much of a policy."

Fitness for duty can be made company policy. Courts have confirmed that urine tests can be used for fitness for duty purposes if there is reasonable possibility the safety of employees, the general public, or company equipment may be jeopardized.

Mr Bensinger said first line supervisors should be educated to look for demonstrable changes in individuals they suspect of drug use and detemine if there is any question they are not performing their job safely and efficiently.

Supervisors "don't have to be diagnosticians or narcotics agents." All they have to do is their job, and that is to ascertain if the employee is in a safe position to do the job. "If not, then the person should be turned over to someone else who can make that decision," said Mr Bensinger.

He said if an employee is found bringing drugs to the job, the company has no option but to call in the police. If the employee comes to work under the influence of drugs, including alcohol, the company should intervene and involve the employee in an employee assistance program.

UK alc groups consolidate in new national agency

LONDON — A single new national organization to be known as Alcohol Concern (sub-titled The National Agency on Alcohol Misuse) is to replace Britain's four existing national bodies: The Alcohol Education Centre, the Federation of Alcoholic Rehabilitation Establishments, the Medical Council on Alcoholism, and the National Council on Alcoholism.

The new agency will be funded by the UK department of health and social security and will support local services and training initiatives; encourage their extension and improvement; and promote preventive action.

Alcohol Concern is the result of a merger proposal made by Britain's minister of health in October last year based on a recommendation by the National Council for Voluntary Organisations and department of health and social security working party set up to study care provision.

Provincial chiefs seeking common ground

(from page 1)

She emphasized a chairmen's group would not preclude need for the CAF.

"The CAF has a unique role to play in terms of serving as some kind of national voice in the addictions field as a group of volunteers; we (chairmen) have a different role to play."

Traditionally, executive directors of provincial and territorial commissions meet twice a year with federal officials at the Federal-Provincial Subcommittee on Alcohol and Other Drugs. The chairmen's meeting in Victoria was held at the same time.

Ron Draper, director general, health services and promotion branch, Health and Welfare Canada, is co-chair of the subcommittee. He told **The Journal** he fully supports the idea of a national coalition of chairmen "because they are the closest contacts with government.

"Chairmen represent the government they work for, and the CAF is in a position where it can publicly express the opinions of lay people and professionals working in the field. And I think that's quite a different role."

Marvin Burke, executive director of the Nova Scotia commission, and co-chair with Mr Draper of the subcommittee, told **The Journal** chairmen "are the closest links to the political arm of governments, and I think they have an important voice in relationship to the government.

"We (executive directors), as officials, do our minister's bidding, but in terms of policy, policy is a government responsibility.

"We can give recommendations, we can prepare research, and we can prepare different approaches that can be taken, but policy must eventually be decided at the cabinet level and at the senior levels of our commissions. And that means, frankly, the chairs of the boards."

Dr Macdonald of Ontario agreed there are some areas where chairmen may be better equipped to deal: "The federal-provincial subcommittee has difficulty because of constitutional limitations in dealing with important questions like treatment services, which are appropriate for provincial action but not part of federal mandate. It may be possible for chairmen to have useful discussions about the promotion and development of appropriate treatment services."

Mr Stoodley, a CAF board member as well as the chairman of the Nova Scotia commission, told **The Journal** a national group of chairmen could address issues that, perhaps, the CAF could not. "We're a little closer to the political scene than is the CAF at this point. They don't have a lot of money, and that's one of the concerns we have."

Represented at the Victoria meeting were Newfoundland, Nova Scotia, Alberta, Saskatchewan, Ontario, BC, and the Northwest Territories.

Mr Gogo said Quebec hadn't been invited because it has no commission. He said his idea had been to include, at this first meeting, provincial chairmen only; thus the Yukon (Territory) was not there.

Lynn Malinsky, coordinator of alcohol and drug services, government of the Yukon, has written to Mr Gogo about the "oversight."

Meanwhile, Florian Lemphers, director of human resources in the Yukon, told **The Journal** the concept of a coalition "is a good one. I would suspect we would get more support from our individual jurisdictions if we went with some kind of formal meeting." (Mr Lemphers would have represented the Yukon had it been invited to the meeting.)

Ross Wheeler, MD, chairman of the alcohol and drug coordinating council for the government of the NWT, was invited when Mr Gogo visited him prior to the meeting.

Dr Wheeler told **The Journal**: "I think there is a lot of value (in a coalition) if we, as a group of chairpeople, see it as appropriate to make some stands on national issues, and it would certainly help us in dealing with local issues."

Although Quebec has no commission, its system of alcohol and drug treatment services is based on 11 Centres d'Acceuil (**The Journal**, Sept), funded by the provincial ministry of social affairs. Fondation Domrémy is one of the largest of those centres and also conducts research.

Domrémy's director-general and CAF board member Maurice Prévost told **The Journal** that Quebec would be interested in exchanging views about alcohol and drug abuse with other provinces, and in collaborating with the chairmen. He suggested a coalition of chairmen might best be operated as a subcommittee of the CAF.

Of other provinces not at the meeting, Mark Triantafillou, MD, director of Addiction Services, PEI, told **The Journal** a formal meeting of chairman should not "duplicate somebody else's work. If the terms of reference produce a different sort of impact toward progress I would think it would be a good idea."

Draper

Macdonald

However, Everett Chalmers, MD, chairman of the New Brunswick Alcoholism and Drug Dependency Commission, said his experience at national medical meetings in the past is that "we have so many diverse opinions — geographically, racially, religiously, and the rest — that we always end up with some wishy-washy kind of resolution. I don't know whether the chairmen may be a little more powerful or have more clout or not, but you have really got to hammer the federal government to get them to move on anything."

Stan Remple, assistant deputy minister of community health services in BC, attended the meeting. At press time, however, the majority of that province's offices were closed down by a public-sector strike, and he was not available for comment.

In Manitoba, Gary Miles' term of office as commission chairman had ended, and the appointment of Monsignor Charles Empson to chair the board of the Alcoholism Foundation of Manitoba did not take place until after the Victoria meeting.

Saul Cohen, MD, chairman of the Alcoholism Commission of Saskatchewan was on holidays.

High-level drug criminals target of FBI/DEA efforts

By Harvey McConnell

WASHINGTON — Arrests of drug traffickers have increased by 122% and convictions by 61% in the first half of 1983 through combined efforts of the United States Federal Bureau of Investigation (FBI) and the US Drug Enforcement Administration (DEA).

William Webster, FBI director, said that in the 18 months the two agencies have been linked (**The Journal**, March 82), FBI drug-trafficking investigations have increased to 1,500 from 100, and more than 500 of them are joint operations with the DEA.

He told the conference of the National Federation of Parents for Drug-Free Youth here that FBI-DEA interest is not in the street-corner pusher but in "organized crime in drugs, financial crime in drugs, and political corruption in drugs."

Their concern is in "those doing the most damage — the manipulators, managers, and operators of the distribution network."

The cooperative effort means the DEA is now able to do things it could not do in the past because it didn't have the manpower; with the help of FBI agents, the number of court-authorized wiretaps by the DEA has more than quadrupled.

Mr Webster: "We simply have to increase the cost of doing business in drugs. We must make the drug dealer pay dearly in terms of cost if we are going to have any effect at our end of the spectrum on the enormous amount of supply coming into this country."

In one recent operation, eight undercover operatives, whom Mr Webster visited several times, laundered some $170 million in cash for a Colombian drug cartel operating in Florida. Eventually, 36 arrests were made and the FBI confiscated $6 million cash, $11 million in bank accounts, numerous planes and cars, and 4,600 acres of land valued at $4 million.

Old-line mafia families have moved into the business, and fear and intimidation are their major weapons to frighten away potential witnesses. One ring in Cleveland murdered seven people before its leaders were arrested, he said.

Webster: making the dealer pay

The amount of money involved in drug trafficking means tempting bribes can be offered to public officials. As the head of one law enforcement association told him: "How long would it take a $9,000-a-year deputy sheriff to save $50,000 when he can make it in one night, or one week, by being somewhere else?"

He added: "Narcotics operations on this scale would not be able to function without the cooperation of corrupt public officials." These include judges, police officials, and even government prosecutors, he said.

Mr Webster pointed out there is not enough manpower to cover every isolated landing strip, every remote cove or inlet in the US. "Drugs will get there if people want them to come.

"We are working hard to get foreign countries to crack down on producers, and we are prosecuting our own domestic growers and manufacturers. But as long as the demand exists, there will be those who attempt to supply the product."

Dominick DiCarlo, (**The Journal**, March 82) assistant secretary of state for international narcotics matters, said that the US, as a signatory to international laws, cannot pick and choose at home which drugs it will concentrate on, and which it will ignore.

"That's not going to wash in the international community," he said. "We cannot go to these countries and ask them to do something about their production of the opium poppy and the coca bush and we do nothing about our own domestic cultivation of marijuana."

No use is 'recreational' Mayer tells parents

By Harvey McConnell

WASHINGTON — The term "recreational use" must be ditched once and for all.

"I don't think there is such a thing as recreational use of anything which alters the way the brain functions at any time in life, particularly when the central nervous system is growing, said William Mayer, MD, outgoing administrator of the United States Alcohol Drug Abuse and Mental Health Administration.

Dr Mayer, in one of his last appearances before joining the department of defense as assistant secretary for health affairs, was addressing the National Federation of Parents for Drug-Free Youth here.

He said he disagrees with many of his trusted colleagues who say one might as well face the fact lots of young people drink alcohol, use pot, "and increasingly, I suppose, are tempted to use other kinds of chemicals."

To face that fact does not mean it should be approved or accepted as a fact about which nothing can be done, he said.

Dr Mayer: "We have to face the fact there are nuclear weapons in the world, we have to face the fact there are something like 40 separate wars going on right now.

"We can't individually, perhaps, do anything about those. But, to extend that thinking to say a lot of kids drink alcohol, and usually just beer, and everybody knows beer is benign, and, therefore, to simply drop it, accept it as something we have no impact on, is to accept a kind of impotence which I think no parent anywhere in the world could possibly sit still for."

Dr Mayer said he has nothing against the beer, wine, or spirits industry and their products, but facts about alcohol should be known "and the kid who chug-a-lugs five or six cans of beer is in a very dangerous situation. That can't be considered responsible."

He called on parents to learn as much about alcohol as they have about other drugs. Although most adults consume alcohol in amounts and at times which do not interfere with their functioning, and do not act in an irresponsible manner, "to expect out of some distorted idea of egalitarianism or democracy because we can do it, therefore kids ought to be allowed to do it, is just wrong. And we should say that."

BC drug programs frozen, not cut

VICTORIA, BC — Alcohol and drug treatment programs in British Columbia have escaped the worst of the axe of government restraint.

While many social programs have been slashed, the drug programs have only been frozen, says John Russell, executive director of alcohol and drug programs for the provincial ministry of health (**The Journal**, Aug).

He told **The Journal** that all alcohol and drug agencies that the government funded in 1982/83 budget year will get the same funding in the current 1983/84 budget year.

The current drug and alcohol budget, in this province of 2.8 million people, is $18.5 million.

Mr Russell's department will spend $1.5 million more than it did last year, but that, he said, is because it has taken over some programs run by the ministry of human resources — for example, a 60-bed emergency housing facility that takes in people with alcohol and drug problems.

The health ministry operates three detoxification centres plus outpatient services in Vancouver, Kelowna, Prince George, and five towns on Vancouver Island.

"Basically we'll be able to manage," said Mr Russell, although he acknowledged that demand for treatment services is increasing.

April and May, the first two months of the fiscal year, saw demand 20% greater than in the same period last year.

"We're doing everything we can to be efficient and see more people," he said.

Salaries, which account for about half the budget, have risen only about 3% in a year.

Prison mini-guards unreliable, corruptible

By Wayne Howell

Recent newspaper reports say federal corrections officials are going ahead with a $60,000 pilot project using gerbils to identify visitors attempting to smuggle illicit drugs to inmates in federal penal institutions (**The Journal**, March). The officials are rather secretive about the project for security reasons, but apparently the tiny rodents have been tested once at the Warkworth medium-security institution and are due for a second trial in the near future.

The gerbils will be placed in cages at the prison entrance, where they will conduct an olfactory survey of every person who ventures therein. If the gerbil on duty detects an illegal substance, he will push a lever which will activate a red light or a clanging bell, and the miscreant will be apprehended forthwith. Following which, the gerbil, in true Pavlovian fashion, will probably be rewarded with a sunflower seed.

The corrections officials are excited about gerbils because they are "less cumbersome than dogs and easier to control," which is certainly true enough. Plus, there are obviously economies of scale — if we are going to put animals to work for us, it makes sense to use ones that will accept a pay-off in sunflower seeds rather than Gainesburgers. (Rumor has it that British Columbia Premier Bill Bennett is planning to replace the entire BC civil service with gerbils for similar reasons.)

But not only are gerbils more manageable than dogs, say the corrections officials, their sense of smell is so acute they can even detect "high adrenaline levels in a prison visitor who is tense or excited while smuggling contraband." (One presumes that this is the discreet way federal corrections officials have of describing the ability of their gerbils to detect human sweat, since a gerbil that could detect circulating adrenal hormones would be a remarkable little beastie indeed.)

It is pleasant to think that gerbils in the employ of the Solicitor-General will clear our prisons of illegal drugs as efficaciously as falcons in the employ of the ministry of transport clear selected airports of unwanted birds. But I have my doubts.

In the first place, I question the assumption that the sensory faculties of gerbils are honed to such a fine edge. Consider the subject of earth tremors. During the last two decades the Chinese have proved that the old-wives tale about animals behaving in a peculiar manner prior to an earthquake is absolutely true. Yet my gerbil did nothing to alert me to the imminence of the October earthquake that made my house vibrate like a tuning fork and scared the hell out of me. He calmly pursued his hobby (eating his plastic exercise wheel) before, during, and after the quake that registered 4.3 on the Richter scale. His nonchalance in the aftermath is even more astounding when one considers that the incident caused in me an adrenaline rush of the kind one might get upon entering Warkworth prison with two ounces of hashish taped to one's thighs. (I though my natural gas furnace had blown up.) The next day I read in the *Ottawa Citizen* about the peculiar behavior of dogs, cats, and caged birds prior to the incident; there was no mention of the prescient behavior of gerbils.

So what, you say. The gerbils are not being employed as seismologists, they are being employed to sniff out illicit drugs. And I agree that just because gerbils are unreliable in matters seismotectonic, it does not necessarily follow that they are unreliable in matters pharmacological. So I will dispense with the preliminaries and get right to the heart of the matter: gerbils are susceptible to bribes.

You may feel that I have unfairly maligned gerbils with this statement. But I stand by it. Go ahead gerbil lovers of America, sue me. In any libel or slander suit truth is the ultimate defence, and the truth is that any gerbil can easily be corrupted by the offering of a soft cellulose-based item that looks like promising nest-building material. Narcotics-squad officers can be "bought" by the judicious application of coin of the realm; mean-looking, hard-sniffing German shepherds can be "distracted" by raw round-steak and beef brisket; but a gerbil can be "turned" by that most disposable of items in a woman's purse or a man's pocket — a single sheet of facial tissue.

I know what you are thinking: he's talking about the common run of gerbils, not the kind of gerbil that can pass the Civil Service competency test, not the kind of highly-motivated gerbil that can profitably absorb bilingual training and can, after only a few short weeks, compute with an error factor of 0.05 the monetary value of the fully inflation-indexed pension he will get after 20 years of loyal federal service. But I make no exceptions; there is not a gerbil alive who will not throw over everything — the security, the indexed pension, the whole bit — for a bit of facial tissue or paper towel or toilet tissue. To put it succinctly, all gerbils will sell their birthrights for a mess of Kleenex.

Federal corrections officials probably fantasize one of their hot-shot gerbils blowing the whistle on James Cagney as he attempts to smuggle illegal drugs to Humphrey Bogart in the Big House. As Cagney is hauled off by security officers, he turns to the gerbil and sneers: "You dirty rat!"

The truth of the matter is that Cagney would probably send 'some dame' (say Lauren Bacall) who would lay a little Kleenex on the gerbil and breeze on through.

NEWS

RESEARCH UPDATE

Unemployed, single women at alcohol risk

Employment status, number of children living at home, and parental alcohol use were seen to have the strongest relationship with the length of time from first intoxication to loss of control in an examination of factors affecting women alcoholics. Mary Fortin, EdD, and Susan Evans, EdD, while at the University of San Fransisco, examined the affects of 10 variables on loss of control in 50 women alcoholics who were volunteers from Alcoholics Anonymous groups in northern California. Unemployed, single women with parents who were alcoholics were seen to face a "great risk" of developing alcoholism more quickly as indicated by the length of time between first intoxication and loss of control. Because the region from which the study group was drawn has many single, working women, and fewer families than many urban centres, the researchers said the study may be most useful in other areas with similar makeup.

Journal of Studies on Alcohol, September, 1983, v.44:787-796

Prolonged LSD reaction and schizophrenia

Researchers from the Albert Einstein College of Medicine and the Bronx Psychiatric Center, Bronx, New York, looked at 52 patients classified as having LSD psychosis. Twenty-one of the patients and a similar number of first-break schizophrenics, who acted as a comparison group, underwent extensive testing when hospitalized and three to five years later. In most respects, the LSD psychotics were fundamentally similar to schizophrenics in geneology, phenomenology, and course of illness. The study concluded LSD psychosis should not be regarded as an entity distinct from acute schizophrenia but rather as the interaction of the acute psychotic decompensation precipitated by the LSD, or whatever crisis motivated the drug's use, with the chronic, pathologic, premorbid traits of the patient.

Archives of General Psychiatry, August, 1983, v.40:877-883

Focus on lifestyle may aid drunk drivers

Two Mississippi researchers have found that just administering part of a questionnaire on alcohol use appears to reduce significantly recidivism among a certain group of drinking drivers. Ronald Neff and James Landrum, of Mississippi State University, made the discovery during a follow-up study of drinking drivers. During an evaluation of 3,050 convicted impaired drivers in Mississippi, administration of the Current Status section of the Life Activities Inventory (an 82-item self-administered questionnaire developed in Denver) significantly reduced recidivism in the group of impaired drivers defined as being lower-risk drinkers. The relevant section of the questionnaire focuses the attention of people on in-depth aspects of their life with the predominant focus on problems created by individual lifestyle. The researchers suggest simply completing the questionnaire may force people voluntarily to make negative conclusions about their own actions and promote a private, voluntary decision to change.

Journal of Studies on Alcohol, September 1983, v.44:755-768

Mothers' smoking affects children

Over time a mothers' smoking can do progressive damage to the function of her childrens' lungs, says a study of the effects of maternal smoking on children and adolescents. A random sample group of 1,156 white children from 404 families in East Boston, Mass, aged between five and nine years in 1974 were chosen to receive annual pulmonary function tests for seven years. After controlling for the childrens' original pulmonary function, age, sex, height, change in height, and childrens' smoking habit, the study found the lungs of non-smoking children with mothers who smoke grow at only 93% of the growth rate in non-smoking children whose mothers do not smoke. The researchers at Brigham and Women's Hospital, Beth Israel Hospital, and Harvard Medical School, all in Boston, conclude that along with the childrens' own smoking habits, maternal smoking "may be important in the development of chronic obstructive disease of the airways in adult life."

New England Journal of Medicine, Sept 22, 1983, v.309:699-703

Methadone users fare poorly in alc programs

Treatment programs for alcoholics on methadone maintenance for drug addiction do not appear to be effective, a study indicates. Researchers from the Mount Sinai School of Medicine, City University of New York, conducted a randomized prospective study of 625 drug addicts on methadone maintenance; 17% were classified as active alcoholics and 8% as inactive alcoholics. The active alcoholics were divided into two treatment groups, abstinence or controlled drinking, and a control group which received no specific intervention for alcoholism. The study found that all active alcoholics in the study showed a decrease in alcohol consumption "regardless of participation in therapy specifically designed to diminish their alcohol consumption." The findings also indicate remission from alcoholism "was unrelated to specific treatment groups." The researchers stressed that the study did not advocate the elimination of intervention programs for alcoholism but said more work is needed to define effective therapy interventions.

American Journal of Psychiatry, July, 1983, v.140:862-866

Pat Rich

Ads must be precise in UK

Stiff warning for drug makers

LONDON — In a cryptic "you have been warned" letter, the British department of health has told pharmaceutical companies to clean up their advertisements to doctors about prescription drugs.

Severe action, including legal sanctions, will be enforced in the future. The letter said most advertisements are satisfactory but a small number by unnamed companies cause great concern.

Drugs must not be promoted for conditions for which they were not licensed by the Committee on Safety of Medicines. "This is a particularly dangerous area," the letter said.

A second concern is advertising of drugs in anticipation of their approval by the Committee on Safety of Medicine. "This is quite unacceptable," the letter said, "and vigorous action may be expected against those who attempt to anticipate a favorable decision of the licensing authority."

Thirdly, the letter said, the department will not tolerate claims being made about a drug without hard data to support them. This applies particularly to side effects.

Cumulative effort would counter pro-drug messages: Kirkpatrick

By Harvey McConnell

WASHINGTON — Aggressive "counter counter-culture" messages are the only way to change the perception about drug use, believes Thomas Kirkpatrick, president of the National Association of State Alcohol and Drug Abuse Directors in the United States.

Everyone in the substance abuse field is asked over and over again why people use drugs, and why do young people start using drugs, Mr Kirkpatrick told the conference here of the National Federation of Parents for Drug-Free Youth.

The answer is simple: "One general way of looking at it is a matter of social control, the messages and reinforcements people get to do something or not do something.

"And people are bombarded with messages from media figures, from entertainment figures, from music, from their leaders, from their political figures, from their friends, to use drugs. And they do. The only way you will ever stop it is to change the message."

The message, in turn, cannot be changed until it is attacked every time it appears. Thirty-second 'spots' will never change attitudes until they are augmented by thousands and thousands of "counter counter-responses," and assertions of values.

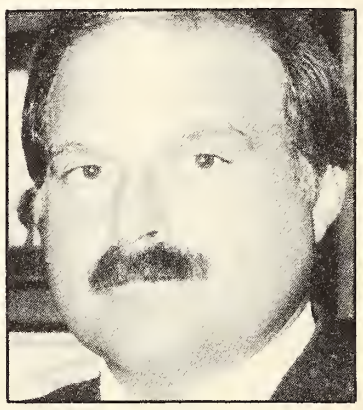
For the first time, there has been a change in the messages which young people are receiving about drugs; the studies which show a decline in positive attitudes about marijuana, and its availability among young people (**The Journal**, April) are a result.

Mr Kirkpatrick said there is a long way to go. "I think that in order to counter the cumulative effect of these media, and public, and private pro-drug messages we need a cumulative effect of all the different groups that are working in the field."

Involvement of doctors, pharmacists, volunteer organizations, and other groups "will, eventually, over the years, accumulate and have the same cumulative effect that just the opposite message has had for the last 10 years."

Mr Kirkpatrick, who is also director of the Illinois Dangerous Drugs Commission, said that with his agency "if there is an issue and a stance we can take which can contribute to the counter message, to the anti-drug message, then we take the initiative."

State agencies can be strong advocates and they are in a position to be. Mr Kirkpatrick told the delegates if they have not talked to state directors they should "because they can play a very supportive role for all the programs you are interested in, and, if they are doing their jobs right, they will be very glad to hear from you and get your support."



Kirkpatrick: heads in the sand

He acknowledged he "may get in a little trouble" with colleagues in some states "because traditionally in this business, as in any other, some people like to keep their heads in the sand and don't want to deal with the hard public issues that confront us."

Mr Kirkpatrick said that under a new Illinois law, fines for possession and sale of drugs have risen by as much as 1,000% in each category, and proceeds from fines are earmarked for law enforcement agencies and a special fund for juvenile drug abuse prevention and treatment.

The next step is to educate the judiciary about the changes "and to pressure the judges to use the law when it is appropriate, because if there isn't any community pressure, there won't be any fines, and if there aren't any fines, there won't be any money."

He plans to work with parent groups and hopes it will evolve that the community in which the fine is levied will get the money "and in that way put some real leverage on judges."

Mr Kirkpatrick said a constant theme of his has been that government can't do everything alone: "We can't keep up with the number of people lined up outside doors of the treatment centres, and we need public support, community support, private support. I've been saying that for the first five years of my job to an empty room, but things are different now."

Pro-pot lobby is wrong on facts, politics: DuPont

WASHINGTON — The United States marijuana lobby has adopted medical and environmental guises in order to muddy the water about the drug — and it is a fraud, charges Robert DuPont, MD, director of the American Council on Drug Education.

At one time, the lobby pushed for decriminalization, "but they can count the votes and they know that decriminalization is dead; no state has decriminalized since 1978," (**The Journal**, Feb 76) Dr DuPont told the conference here of the National Federation of Parents for Drug-Free Youth.

He said "these relics from the 1960s went into a phone booth and they came out dressed as doctors concerned with the medical use of marijuana, and environmental scientists concerned about paraquat (spraying of marijuana) and the environment.

"They are in postures that are a fraud. This is simply an attempt on their part to continue their primary objective, which is to give us a confused message about marijuana with the implication that somehow it is okay.

"They are wrong on the facts, and they are wrong on the politics."

Dr DuPont, former director of the US National Institute on Drug Abuse, called members of the pro-marijuana lobby "the pied pipers of our society" who are "dangerous and destructive." And "to treat this as if it were a casual or humorous activity, or a political sideshow, is a tragic misunderstanding of the seriousness of the issues that are involved, and the damage they can do."

Contrary to what many experts espouse, the issues are simple, not complex, Dr DuPont believes. "Do we say no to drug use, or do we say yes? It is true to say any society gets what it asks for when it comes to drugs.

"Facts do matter. We thought they didn't 10 years ago."

Dr DuPont said these issues of drug use must be addressed to teenage alcohol use as well. "The nettle must be grasped because if we just treat it as an okay rite of passage we will continue to have enormous problems."

DuPont: relics from the 60s

NEWS AND COMMENT

Early intervention key to BC controlled drinking success

By Tim Padmore

VANCOUVER — An early intervention/controlled drinking program for alcoholics here appears to be paying off.

First results of a follow-up of the Vancouver health department's Skills program indicate about 70% of participants reduced their drinking, or were abstaining, after two years.

Lynn Alden, PhD, the University of British Columbia psychologist who conceived the program, told **The Journal** that controlled drinking is only one part of the program.

A second thrust is early intervention. The program screened out people with a history of hospitalization for alcoholism or detoxification and those who had been through Alcoholics Anonymous.

While there were some heavy drinkers — up to 80 or 90 ounces of spirits per week — best success was observed with moderate drinkers who consumed less than 50 or 60 ounces a week. Mean consumption was about 40 ounces a week.

Among the heavy drinkers, the best candidates were those who had been drinking only for a short time — in the wake of a crisis such as the death of a spouse, for example.

A third element was treatment setting.

People came for treatment at the city's health centres, where immunizations, pre-natal clinics, and other services are provided.

"It de-stigmatized the program," said Dr Alden. "Many clients didn't want to go to the (provincial government) Alcohol and Drug Commission centres. They didn't want to admit they were addicts — especially the women."

Skills administrator Irene Fairley said clients are often referred from within the health centre: "They can come into the health department for any kind of service we have to offer, not as people identified as alcoholics."

The program was developed in 1977 by Dr Alden and Dr Fred Bass of the Vancouver health department. After a one-year pilot, Health and Welfare Canada funded a four-year demonstration project.

Final interviews of the two-year follow-up were being conducted this fall.

(Results of the pilot study are discussed in Alden, L., *Canadian Journal of Behavioral Science*, vol 10, p 258-263, 1978.)

Dr Alden said 80% of the clients have cooperated in the follow-up, with client reports verified in more than half the cases of a family member or "significant other."

The follow-up involves more than 150 clients, who kept logs of their drinking and came in for six-monthly interviews.

Dr Alden said there was no correlation between treatment success and age, sex, or parents' drinking habits. The only correlation so far is with the level of drinking on entry.

Four or five counsellors and a supervisor are on staff. Program coordinator Doug Adams estimates more than 100 people a year go through the program.

Problem drinkers come in many forms, he said: "There is the person who may not drink that much in a week but drinks it all in four hours.

"There are others who consume a great deal but who space it throughout the day so they never really get drunk. They believe they are controlling it, but they are still keeping a buzz on."

Clients come in for weekly, hour-long counselling sessions. Consumption goals are set, aiming at cutting drinking down to less than two or three drinks a day. Clients should also abstain from alcohol at least three days a week.

Drinkers are taught to monitor their own blood alcohol levels, and to avoid letting them exceed 0.08%, the legal level for impairment in the operation of a motor vehicle in BC.

For some, said Dr Alden, it doesn't work. "About a third decided it was too much trouble to control their drinking and went for abstinence instead."

Lifestyles of patients are also examined.

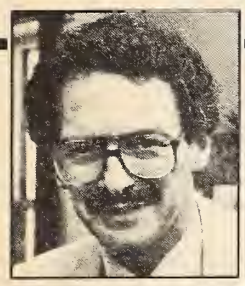
"Most of these people have very constrained lifestyles, centred around alcohol," she said. So they are encouraged to develop other social contacts, to jog, or join a health club. "I don't think you can just take away drinking. You have to add something to their life."

Typically, positive results are seen in six to eight weeks. People who don't cut down at that stage are poor prospects for eventual success, Dr Alden said. The program is cut off at about 16 weeks, unless a client seems on the verge of a breakthrough.

Next month in THE JOURNAL

- *Calendar '84*
- *Compulsive gambling*

GILBERT



'of particular note are two reports . . . published during the past few months.'

Optimal alcohol use: I

By Richard Gilbert

This month and next month I want to return to consideration of the preventive effects of alcohol use, which I discussed in some detail in three of these columns in the spring of 1980.

I concluded that series with some statistical gymnastics to the effect that alcohol had caused 1,670 deaths in Ontario in 1974, about half from automobile accidents, and prevented 2,100 deaths from heart disease (**The Journal**, May, 1980). Thus, in terms of mortality, the use of alcohol lead to a net benefit of 430 lives in 1974. I concluded further that the number of deaths prevented would have been little different if average alcohol consumption had been one drink a day rather than the actual value of close to two drinks a day, or if it had been three drinks a day. The number of deaths caused by alcohol would, on the other hand, have been dramatically different —just 690 if average consumption had been one drink a day, but 2,600 if it had been three drinks a day.

Net benefit

Thus, in as much as my estimates were valid, alcohol consumption in Ontario in the mid-1970s was such as to provide a net benefit to society in terms of mortality. The net benefit would have been greater if average consumption had been lower. It would have been smaller if consumption had been higher. Indeed, if consumption had been 50% higher there would have been a net cost rather than a net benefit.

The average alcohol consumption of the population is the most important variable in estimating both deaths caused and deaths prevented by alcohol use. Because average consumption has changed little in Ontario since 1974, my earlier estimates may have some application today.

Because the net benefit of alcohol use in terms of mortality would be greater than now if average consumption were about half the present level, but zero if no alcohol were used at all, it follows that there is an optimal level of average alcohol consumption by Ontario residents above and below which the net benefits would be lower. This optimal point is near half the present level of consumption.

My statistical edifice of costs and benefits rested on a pillar of evidence to the effect that moderate alcohol use has a protective effect on heart disease. This pillar was a little shaky in 1980. Studies reported since then provide more support.

Of particular note are two reports, one epidemiological and one experimental, published during the past few months.

The first is a prospective study of 10,000 Yugoslav men, conducted by D. Kozarevic and colleagues and reported in the *International Journal of Epidemiology* in June this year. The authors concluded: ". . . consumption of alcoholic beverages was inversely related to non-sudden death from coronary heart disease and positively related to death from trauma. The consequence was an apparently U-shaped relation between alcohol consumption and death, the lowest mortality being among moderate drinkers."

Because recent drunkenness at the time of entry into the study was related to death from trauma and liver cirrhosis, and to sudden death from coronary heart disease, the authors concluded further that ". . . both the pattern of the drinking and the usual level of alcohol consumption appear to be related to mortality in this population."

This study is important not only because of the large sample but also because it was prospective, ie, it was planned in advance and the alcohol consumption of the subjects was determined at their entry into the study without knowledge of their fate. More frequently such studies are retrospective: the prior alcohol consumption of groups having different mortality characteristics is determined, and conclusions are drawn as to the extent to which differences in alcohol consumption were responsible for the differences in mortality. Compared with prospective studies, retrospective studies suffer not only from the errors involved in determining historical data, but also from intrusion of bias on the part of researchers in selecting the samples to be compared.

Both kinds of study provide conclusions based on correlations that might turn out to be causally spurious. The apparent U-shaped relationship between alcohol use and mortality may be the product of an important third factor of more causal significance. Tobacco use may be such a factor. A study of the smoking and drinking habits of 7,735 British men reported in the *British Medical Journal* in 1981 by R.O. Cummins and colleagues found a tendency for moderate drinkers to smoke less than abstainers and heavy drinkers. Thus the benefits of moderate alcohol use might occur because of the moderate smoking habits of moderate drinkers rather than as a result of any intrinsic property of alcohol. The question then arises, of course, as to why moderate drinkers smoke moderately in comparison with their abstinent and boozy compatriots.

More plausible account

Perhaps a more plausible account of the apparent benefits of moderate alcohol use comes from the second recent study of significance that bears on this issue. It is a report in an October issue of the British journal *Lancet* by John Thornton and colleagues concerning the effects of moderate alcohol intake on blood-plasma levels of high-density lipoprotein (HDL) cholesterol and on bile cholesterol saturation. This was a report of an experimental study. The researchers actually *manipulated* what was believed to be the causal variable rather than rely on its variation as a result of other causes. These other causes may very well also have a powerful determining effect on mortality, HDL cholesterol levels, or whatever else is being investigated. Experimental designs serve to reduce the involvement of such extraneous variables. For this reason, conclusions about causation may be drawn more confidently from experiment than from observation, even if the observation is conducted according to a prospective design.

Thornton and his co-workers studied 12 healthy, middle-aged volunteers who normally used only small amounts of alcohol. They drank half a bottle of wine a day for six weeks and then abstained from alcohol for a further six weeks. At the end of the first six-week period, HDL cholesterol levels were significantly elevated. They returned to pre-wine-drinking levels after abstinence from alcohol. Other measures of cholesterol and triglycerides did not change, except that the mean bile cholesterol saturation fell significantly during the first period and returned to pre-experimental levels during the second.

The finding that alcohol-beverage consumption induces elevated HDL cholesterol levels is important because HDL cholesterol is well recognized to be an anti-atherogenic agent, ie, it prevents the accumulation of fatty material on the lining of the arteries. There have been suggestions in the past that alcohol use increases HDL levels, but these have come mostly from epidemiological studies. Previous direct experimentation on the topic has produced conflicting results. This study seems to clarify the existence of the phenomenon.

The study also adds support to a lesser body of evidence linking the incidence of cardiovascular disease with that of cholesterol gallstones. Regular, moderate drinkers would appear to have a reduced risk of gallstone formation compared with abstainers.

The authors noted other evidence to the effect that larger amounts of alcohol can raise plasma triglycerides, and possibly, as a consequence, *contribute* to cardiovascular disease and increase incidence of gallstones. Such evidence further strengthens the notion that the U-shaped relationship between alcohol use and mortality results from the combination of protective and injurious effects that is so balanced to provide increased protection up to a point and then increasing harm at higher consumption levels.

Other evidence

Other evidence for a U-shaped relationship between alcohol use and mortality has been published since 1980. A study of 3,665 Swiss adults by J. Alexander and B. Junod, reported in 1981 in *Schweizerische Medizinische Wochenschrift*, concluded: "It appears that for both sexes the larger the population regularly drinking a moderate quantity of wine, the lower the mortality rate."

A study of 1,422 male civil servants by M.G. Marmot and colleagues, reported in the *British Medical Journal* in 1981, concluded: "Over 10 years of follow-up, the mortality rate was lower in men reporting moderate alcohol intake than in either non-drinkers or heavier drinkers (greater than 34 grams of alcohol a day). Cardiovascular mortality was greater in non-drinkers and non-cardiovascular mortality was greater in the heavier drinkers."

A study of 9,150 Puerto Rican men, reported earlier this year by S.J. Kittner and colleagues in the *American Journal of Epidemiology*, found, after adjustment for age, "clear evidence of a U-shaped relationship between alcohol and total mortality," although "there was no evidence of a 'protective effect' of alcohol consumption in the older and poorer segments of the population."

Next month I'll consider further the implications of the evidence on the medical benefits of alcohol use for our alcohol control policies.

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Gilbert column 'strikes a chord'

Logical drinking age is 26

I was intrigued by Dr Gilbert's column, The drinking age debate (**The Journal**, Sept). His passing suggestion that serious consideration might be given to raising the legal drinking age to 25 years for men and lowering it to 18 years for women struck a responsive chord in my thinking on this topic.

North Dakota is one of the few states in the United States which has not lowered its drinking age from 21 years. I have been a chief proponent of not reducing the legal age for the last six years and have testified and lobbied strenuously during that time against reducing the legal drinking age below age 21.

In such testimony, I have periodically proposed that the logical drinking age should be 26 years. I have not considered a reduced or different age for women.

The rationale for my preposterous suggestion has been much like Dr Gilbert's and based upon driving fatalities.

Another dimension of equal importance to addiction clinicians, however, is the question of the age of onset of the disease, alcoholism, and its treatability. It's a fairly well-established presumption in our field that alcohol (or any other drug) dependency creates an arrest of emotional maturation. The clinician, therefore, is often faced with an individual of a chronological age of 30 years but with an emotional age of perhaps 15 or 16, which is the point at which his alcoholism took over and maturation ceased.

Because of this cessation of emotional maturation, and the inevitability that a certain portion of our population will be alcoholic at some age in their life based upon their genetic and, perhaps, emotional makeup, it would seem logical to postpone the onset of the disease until such time as emotional maturation has fully developed.

My estimate is that 26 years is the age of adult emotionality for the average North American (this is based upon the empirical research I conducted one night at a local cocktail hour. When I made this proposal to six people, none of them disagreed . . .).

The median beginning drinking age of the average North Dakotan is now below 12 years of age, and it has dropped from nearly 13 years of age in a seven-year period.

We are seeing and can demonstrate an increasing amount of abusive drinking among teenagers at fairly young ages and, obviously, well over half of them are beginning to drink (although not necessarily abusively) before they are 12 years of age. All of this is supporting our clinical observations that we are seeing full-blown alcoholism among people in their early teens, and we are seeing patients in their 20s and 30s who have developed alcoholism in their teenage years.

I will certainly find Dr Gilbert's article useful in the future testimony and debate, although I believe the issue of age reduction, in our state at least, is no longer viable. I trust this information is of some help and support.

Thomas R. Hedin
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North Dakota Department of Human Services
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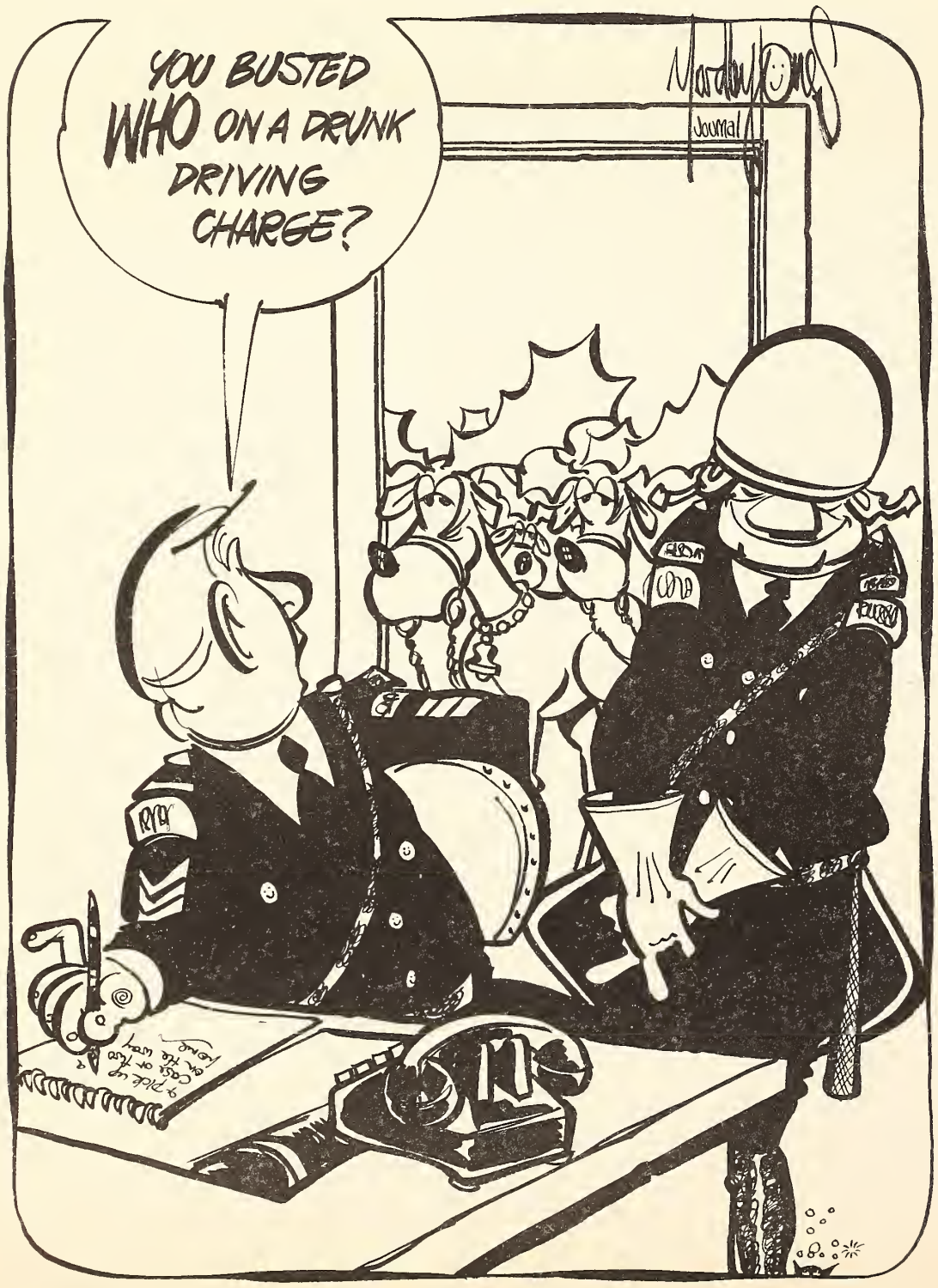


UK does allow heroin for treatment of addicts

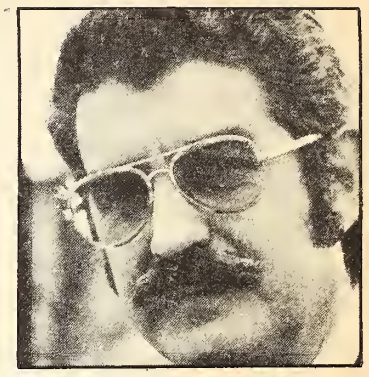
Your article on my views regarding the current drug scene in England, by Harvey McConnell (UK in danger of making US heroin mistakes, **The Journal**, Oct) was excellent. It accurately reflected the reality of the situation.

However, the box accompanying the article contained one small but significant error. Despite widely-held belief to the contrary, British law does not forbid the use of heroin in the treatment of addicts. Rather, the Dangerous Drugs Act of 1967, following the advice of the second Brain Report, created a category known as "restricted drugs." In order to prescribe such drugs for addict treatment, doctors had to receive special licences from the Home Office. The first drugs placed in the new restricted category were heroin and cocaine. Approximately 600 physicians have been granted these licences. Most work in the drug dependence clinics.

The coordinated clinical decisions of these doctors, not the law, have been the moving force in the reduction of the use of injectables, mainly heroin and methadone. These medical decisions have been made, moreover, in the face of the expressed dismay of some of the leading officials of the Home Office Drugs Branch.

Even though heroin in maintenance treatment has been greatly reduced, however, the licensed doctors have not eliminated it. In 1981, 102, or 3% of all addicts in treatment, were receiving prescribed heroin only. While small, this was almost twice the number in 1980. If all the addicts receiving prescribed heroin alone *and* in combination with other drugs were counted, the number becomes 208 or 5.4% of the total. Figures for 1982 show even greater use of prescribed heroin.

Most of the addicts receiving heroin by prescription are long-established injectors. The dosages provided are huge — with prescriptions of hundreds of milligrams of pure heroin daily being common. British drug abuse specialists and medical leaders often act as if such patients and such dosages do not exist, but they do.



Trebach: calm moorings

The trend, of course, is in the opposite direction, as accurately reported in the article. The United Kingdom drug abuse establishment now seems intent on following the advice of the recent Duckworth Report and putting all opioids in the restricted category. This would be a disaster. One hopes they return to their calm cultural moorings and avert their gaze from cousins across the Atlantic, whether in the United States or Canada.

Arnold S. Trebach,
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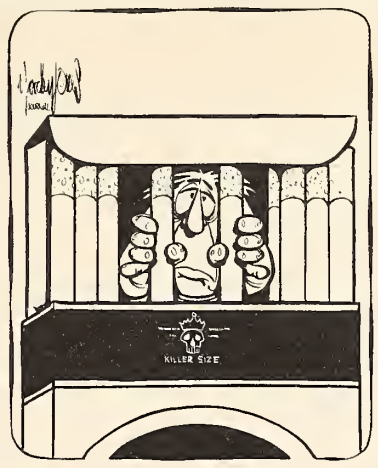

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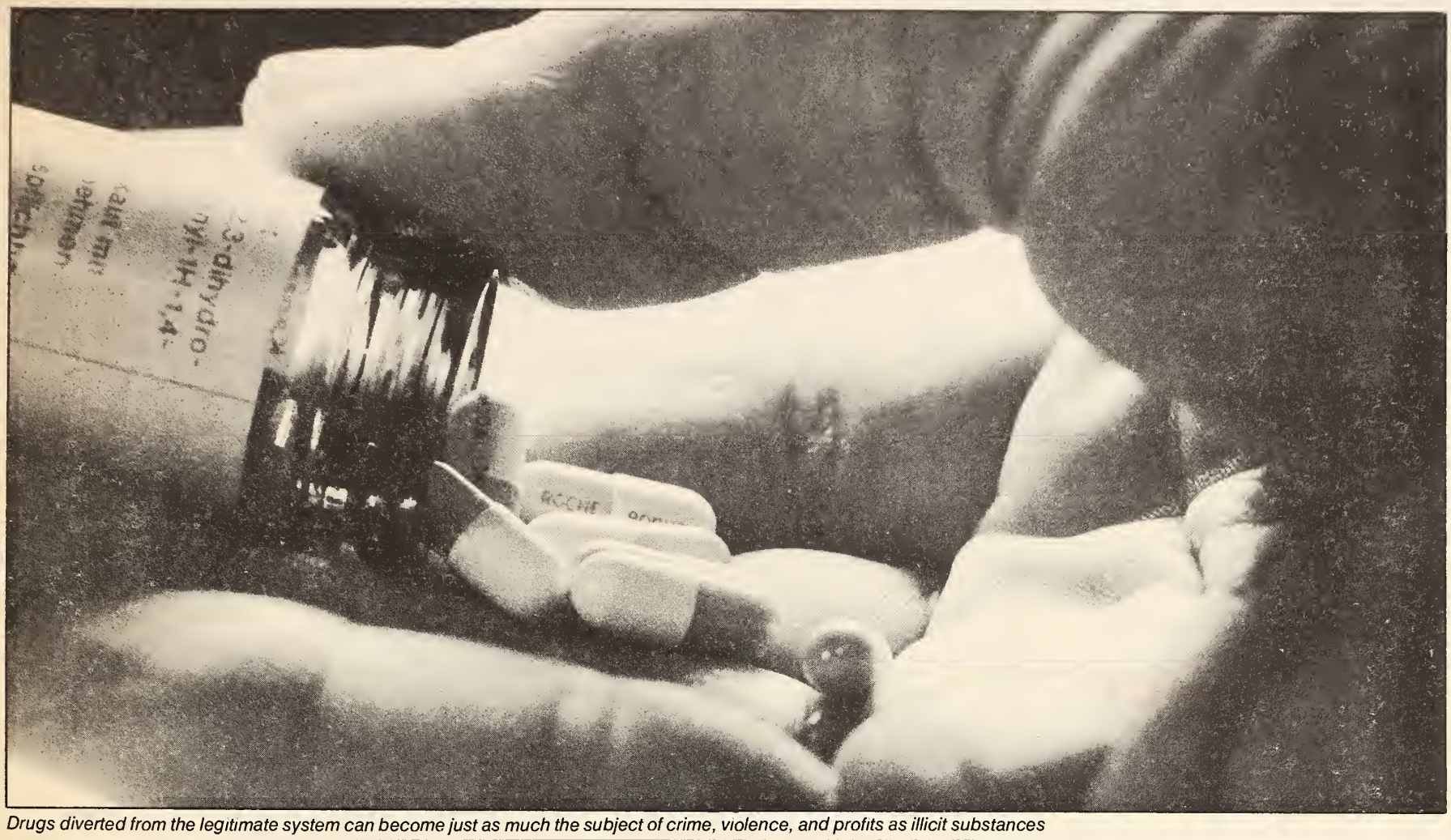


Golobitsh

Drugs diverted from the legitimate system can become just as much the subject of crime, violence, and profits as illicit substances

Educated physicians, pharmacists, and patients are key

Leaks in drug pipeline need stopping

By Harvey McConnell

WASHINGTON — Attacks on prescription drug abuse must be aimed at those who divert the drugs and not at the drugs themselves.

This should be done in conjunction with better education of the medical and pharmaceutical professions and of patients, several speakers pointed out at the annual conference here of the Alcohol and Drug Problems Association of North America.

Barry Rhodes, of Odyssey Resources, Bridgeport, Conn, pointed out: "The abuse of prescription drugs results in more injuries and deaths in the United States than all illegal drugs combined. Of 1.5 billion prescriptions dispensed in the US each year, several hundred million dosage units are diverted to illicit use."

Along the pipeline from manufacturers to patients, the major leaks of drugs are at the pharmacy and medical practitioner levels. "Prescription blanks are stolen, drugs are stolen from pharmacies, and deviant practitioners prescribe and dispense drugs with criminal intent to make a profit from drug abuse," he added.

David Joranson, drug abuse specialist with the Wisconsin Controlled Substances Board, Office of Alcohol and Other Drug Abuse, said: "The drugs that are diverted from the legitimate distribution system can become just as much the subject of crime, violence, and extraordinary profits as the illicit substances."

One of the long-term consequences of prescription drug abuse and the way in which problems tend to be aggravated by not being solved "is the reduced credibility on the part of the public about some useful medications they could otherwise benefit from.

"We've seen situations where people who are in need of pain medications have difficulty getting them because practitioners have been so driven away by the headlines about their drug abuse potential."

Mr Joranson, who has been involved in Wisconsin's successful inter-agency attack on diversion in recent years, said long-term diversion control efforts must recognize "it is not the drug itself but rather the mechanism of diversion, that is the 'script' doctor or dishonest pharmacist, who must ultimately be eliminated."

The crackdown in Wisconsin has brought a drastic reduction in script doctors, and officials are confident some outbreaks of prescription drug abuse will not return.

At the same time, the system allows officials to keep a sharp eye on a trend elsewhere — such as a recent rise of glutethimide-codeine combinations in Chicago — and spot it if it starts in Wisconsin.

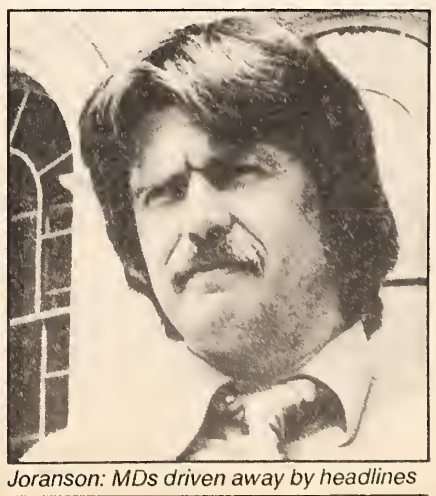
Successful interventions have reduced the prescribing of amphetamines by 80% to 90%, matched by a 90% decrease in arrests for amphetamine-related violations and a 60% drop in treatment admissions in Wisconsin.

There has been an 80% to 90% drop in prescribing of barbiturates and methaqualone, and a 55% drop in barbiturate treatment admissions.

Mr Joranson emphasized that all of the drugs continue to be available for therapeutic indications as outlined by the US Food and Drug Administration, with the exception of amphetamines which, while still available, may not be prescribed by Wisconsin doctors for obesity control.

He added that while ultimately it will be the combined efforts of state and federal agencies, and the professions, that will solve the problem, the absence of any diversion control effort in a state is a fatal flaw.

Bonnie Wilford, senior research associate for the American Medical Association (AMA), said a fundamental fact is that prescription drug abuse, while it is like other kinds of alcohol and drug abuse in many ways, it is also dissimilar.



Joranson: MDs driven away by headlines

The first difference "is that we are talking about drugs that are inherently legal, that are medically useful, and we can't solve the problem by banning the drug." In that respect it is more like the situation with alcohol than other drug abuse.

Secondly, prescription drug abuse is democratic and appeals to a broad spectrum of the population, said Ms Wilford.

"Street-drug abusers find many, many prescription drugs perfectly acceptable substitutes for heroin, for instance, and, in some cases, become so sophisticated they start to prefer it. Middle-class people either unwittingly fall into it as a result of some misguided medical treatment, or actively seek these drugs because they're sophisticated enough to understand the mood-altering possibilities."

Ms Wilford said that as a result of pressures for action, delegates to the AMA annual conference meeting in 1981 called for cooperative efforts to stem prescription drug abuse, and an informal steering committee has been set up representing more than 10 public and private organizations.

A number of projects which have evolved will be unveiled to the public in January. The emphasis is on professional education.

Under development is a video cassette text, instructors guide, and evaluation form package which will be aimed at pharmacists, doctors, nurses, dentists, and veterinarians among others.

Efforts are being made as well to develop patient information programs.

Another outgrowth of the AMA-inspired, inter-agency cooperation has been development of the PADS (prescription abuse data synthesis) system which is now being tested in five states: Arkansas, Florida, Massachusetts, Michigan, and Nevada. It is hoped that within a year the system will be refined and can be used by any state wanting to install it.

Mr Rhodes, who is directing the field trials of the PADS system, said the first step is to bring together state officials who have any kind of information on the supply and demand for drugs.

The stage is then set for the state interagency cooperation which is needed in order first to spot trends in use, apparent abuse, prescribing, and dispensing, and then to develop a response.

Mr Rhodes said the trials have shown that officials in the various state agencies have learned more about each other, about each others' capabilities, and about what they can achieve with cooperative use of central computer banks.

A second group of state officials is involved in looking at the intervention capabilities of the state and in developing a good regulatory response.

Mr Rhodes said the US Drug Enforcement Administration is cooperative in trying to help each state deal with the prescription abuse problem. However, once the problem is pinpointed, intervention requires much cooperation among state officials, "and it's tough to get sometimes."

NEWS

Study designed to measure steel mill smog effect

Moms' smoking tops pollution as risk to kids

By Betty Lou Lee

HAMILTON, Ont — A massive study designed originally to detect any effect of this steel milling city's notorious air pollution on the respiratory health of children has found the most deleterious effects are caused by smoking mothers.

The four-year study was conducted by the Urban Air Environment Group at McMaster University here, and covered 3,500 children aged seven to 10 years. The $1.2-million study was financed by Health and Welfare Canada, the Ontario ministry of health, and the Ontario ministry of the environment.

Principal investigators were L.D. Pengelly, PhD, and A.T. Kerigan, MD, of the department of medicine, C.H. Goldsmith, PhD, of the department of clinical epidemiology and biostatistics, and B.K. Garside, PhD, of the department of engineering physics.

"The effects of second-hand smoke, particularly maternal smoking, were the ones most easily demonstrated," said Dr Pengelly. "Particulate matter in the air didn't appear to have a significant health effect."

Parents answered yearly questionnaires about chest illness, coughing, wheezing, colds, bronchitis, and asthma in the children, and the children were given four sets of lung function tests at school each year for three years.

Factors on which data were collected included how many people in the home smoked, how many people shared the child's bedroom, whether gas was used for cooking, and whether there was forced air heating.

Particulate matter and sulphur dioxide in the air were monitored at various sites in the city.

Dr Pengelly said more respiratory problems were found among children in the north end of the city, where the steel mills are located.

"But that's where we also found worse environmental factors. Eighty-five per cent of the children there lived in houses where parents smoked, compared to 60% in the city overall. There were lower socio-economic levels, and the houses were more crowded."

Pollution: particulate matter appeared to have no significant effect on children's respiratory health

He said maternal smoking probably had more impact than paternal smoking because mothers spent more time in the home.

The data showed the four most important factors in the children's respiratory health were maternal smoking, smoking in the home, hospitalization for a respiratory illness before the age of two years, and maternal cough. (The last two have also been associated with smoking in the home in a variety of studies.)

"Other environmental factors, such as the use of gas for cooking, crowding in the home, and socio-economic factors, showed even less effect (than particulate air pollution)," the group concluded.

They plan to follow the same cohort of children to study the interaction of smoking and other elements in chronic respiratory disease.

"Thirty per cent of them will be smokers by the time they're 18," said Dr Pengelly. "Are the ones who start to smoke the ones with good pulmonary function — are they pre-selected because they have good function and are more tolerant of the smoke? And what will be the course of events if those who have bad pulmonary function to start with start to smoke?"

Nutritional status of alcoholics better than expected, says study

By Harvey McConnell

WASHINGTON — Socioeconomic class can make a significant difference in nutritional status between middle- and lower-income alcoholics, but neither group appears greatly malnourished, suggests a study of 100 alcoholic men in Baltimore, MD.

Robert Goldsmith, professor of chemistry, St Mary's College of Maryland, said most previous studies showing nutritional problems among alcoholics have been among the small group considered skid-row alcoholics. Few such studies have been made of middle-income alcoholics, and even fewer have compared socioeconomic groups.

He and his colleagues examined and compared the nutritional status of 50 middle-income alcoholics and 50 low-income alcoholics attending two treatment centres. Standard measurements included height, weight, triceps skinfold, midarm circumference, hematocrit, and hair pulling strength.

The patients were all male and ranged in age from 25 to 68 years, Professor Goldsmith reported to the annual conference of the American Chemical Society here. All of the men indicated a regular daily ethanol intake in excess of 100g for at least the preceeding 60 days. Excluded were men with liver disease, those who had been in jail in the preceding five years, or those heavily dependent on other drugs.

The alcoholics considered middle class were those who had a regular job, or who had been unemployed for 60 days or less; owned a home or rented a home or apartment; had an income of more than $300 a month; had concerned family and friends, and had an opportunity for a regular diet.

The lower-class group consisted of men with an income of less than $300 a month; with no regular address within the past year; and identified as having inadequate funds to purchase both food and alcohol.

Professor Goldsmith said while the lower-class alcoholics had a significantly lower nutritional status than the middle-class alcoholics, the mean values for both groups were near normal.

A hematocrit value below 39% may be used to indicate anemia; in the study only 6% of the middle-class and 22% of the lower-class alcoholics had a hematocrit lower than 39%.

Professor Goldsmith said the study indicates the middle-class alcoholic's general nutrition is reasonable and the lower-class alcoholic's nutrition better than might be expected from the literature.

"Factors such as a network of other alcoholics, soup kitchens or other food support systems, and other medical factors, can make a major difference in studies of this kind," Professor Goldsmith added.

The study indicates differences in socioeconomic class can make a significant difference in nutritional status between the middle-income alcoholic and the lower-income alcoholic. "Nevertheless, neither group was revealed to be greatly malnourished."

Professor Goldsmith said the indigent alcoholic runs the risk of malnourishment primarily due to a lack of sufficient income, and lack of an adequate support system in terms of family, friends, and residence.

Too much info clogging alcohol treatment field

By Terri Etherington

TORONTO — Information overload in the substance abuse field could be clogging the system and hampering professionals in their efforts to keep up with new developments.

There is "too much to read and too little time to read it," David Levinson of Yale University in New Haven, Conn, told a conference here of substance abuse librarians and information specialists.

The problem is "so serious that it may well be hindering our efforts to understand, treat, and prevent alcoholism," said Mr Levinson, senior associate in research in Human Relations Area Files.

In a recent survey of 100 alcoholism treatment program administrators in Minnesota, 72% said they could not keep up with new developments in the field, and 71% cited information overload as the major cause.

Levinson: folklore takes over

Too much information makes it impossible to tell what has been tested and therefore what is trustworthy, he said. "Thus it is not surprising that any number of ideas widely believed to be true have never been carefully tested."

In these situations, said Mr Levinson, "folklore tends to take over from reality."

Heinonen: a starting point

One way to handle the overload problem is to specialize: "to look at more and more about less and less."

But that will not solve the more general problem. A selection system is needed to winnow the trustworthy ideas — those that have been rigorously tested and supported — from those which are untrustworthy or untested.

He said it's the researcher's responsibility to provide the reader enough information in the report or article to determine which category fits.

The reader should then ask:

- Is the sample representative of the population being studied?
- Is there some indicator that the measure was valid or accurate?
- Were the data accurately collected and reported?
- Could the same results be obtained six months or a year later?
- Has the researcher given enough information so someone else could test the research in exactly the same way with a different sample?
- Have different research designs been used to test the same idea?

Information overload was part of a larger concern among the 25 delegates to the conference — the first joint meeting of the (Canadian) Librarians and Information Specialists in Addictions (LISA) and the (United States) Substance Abuse Librarians and Information Specialists (SALIS). That concern was about the need for better access to and sharing of information in the substance abuse field.

Bette Reimer, newly-elected president of the LISA, said the national focus in coming months will be on the preparation of a directory and a union list of serials in each library holding. Lists of materials put out by parent organizations will also be prepared, said Ms Reimer, chief librarian for the Alberta Alcohol and Drug Abuse Commission.

Ms Reimer told **The Journal** both the US and Canadian groups discussed the need for access to online information and an index system for the field. Dwindling funds for programs in the US, she said, have restricted former information sharing programs.

The need to share information on a global basis was noted by Jarmo Heinonen, of the Library and Information Service of the State Alcohol Monopoly of Finland. Collaboration among libraries could serve as a starting point for an information system about alcohol control experiences, Mr Heinonen said.

"Studies of the impacts of alcohol control in the contexts of different cultures would yield valuable information of wider significance," he said.

"No damn cigar smoke. Is that objection plain enough!"

Addiction week

TORONTO — A public forum at Harbourfront, educational displays at Yorkdale Mall, and presentation of special flags to Metro Toronto Chairman Paul Godfrey, and Toronto Mayor Art Eggleton, highlighted Addiction Awareness Week activities here, October 23 to 29.

The Addiction Research Foundation, Salvation Army, Metro Toronto Police, Donwood Institute, Alcoholics Anonymous, Renascent Fellowship, Al-Anon, and Recovery Homes in Metro Toronto, helped support and organize the week's activities.

US anti-drug parents want support from both sides of the Hill

By Harvey McConnell

WASHINGTON — Leaders of the National Federation of Parents for Drug-Free Youth (NFP) in the United States are concerned that many see the organization as an unofficial arm of the Republican Party, especially if President Ronald Reagan seeks a second term.

Mrs Nancy Reagan has publicly supported the NFP since its founding four years ago and has been a speaker at its two national conferences here. And a galaxy of government officials spoke at the latest conference.

Mary Jacoboson, NFP chairman, said: "We know we have the ear of Mrs Reagan, and we appreciate it. But we are realistic enough to know that in the event President Reagan does not run or is not re-elected our next first lady, of whichever party, will not (necessarily) choose this issue.

"However, we will encourage any first lady and her husband to endorse our program and to recognize it has no political affiliations." tions."

Robert Kramer, new NFP president, noted that at a congressional lobbying reception on Capitol Hill here, which was well attended by both delegates and legislators, "I think we actually had more Democratic senators and congressmen that we did Republicans.

"We have always striven to see our efforts on 'the Hill' are bipartisan. We appreciate the support and commitment to drug-free youth that has come from the President and Mrs Reagan, but from the beginning we have tried to make it bipartisan, and we shall continue to do so."

Mr Kramer said there must be more involvement of minority group parents in the NFP and it has launched a sustained drive to enrol them. There will be more regional and state conferences. Instead of a poor neighborhood trying to raise money to send delegates to a national conference, "we would rather take the message to them."

Paradoxically, it is the very well off, and the very poor, who hold attitudes which must change. Mr Kramer: "Denial is far greater in upper-middle class income communities: 'not my child, our school, our community.' There is also the hopelessness, helplessness syndrome: the problem is too endemic and epidemic; there is nothing you can do about it."

Jacobson: political affiliations

Reagan: a galaxy of officials

Ms Jacobson said the NFP aims to educate professionals and legislators "that alcohol is indeed a drug," and to ignore it is a mistake. This applies to cigarette smoking as well.

She said many requests have come from abroad for information and advice on how to start similar groups. However, because of demands for assistance in the US, NFP officials are going to have to consider what to do about requests from other countries.

A second problem is that in many foreign countries the idea of voluntary work in the neighborhood or community is not as ingrained as it is in North America, Ms Jacobson added.

Trained partner reinforces effort

Spouse support helps smoker quit

By Mark Kearney

TORONTO — Smokers are more likely to quit if their spouses support their non-smoking efforts, says a psychology professor from the University of Oregon.

Edward Lichtenstein, PhD, found that six months after a smoking-cessation experiment, 31% of the smokers who had support from their "partners" during stop-smoking sessions and at home became abstainers. In the same period, only 19% of those in the control group who didn't have partner support at the sessions, had quit, he says.

Dr Lichtenstein, also a visiting scientist with the United States National Cancer Institute in Bethesda, Md, told a seminar here at the Addiction Research Foundation that the quitting rate was slightly better than at regular smoking clinics.

The 64 subjects (27 males and 37 females) had an average age of 38 years. On average, they had smoked 25 cigarettes a day for two years.

The subjects were divided into two groups, those whose "partner" or spouse took part in the sessions, and those without a partner. All subjects attended six, weekly, two-hour sessions including lectures on smoking, group discussions, and homework assignments to help change their habits.

The partners were trained by the researchers to improve their support of the smoker, Dr Lichtenstein says. They learned how to be more helpful to their smoking partner, how to cope when the smoker felt the urge to light up, and how to reward their partner for abstaining.

The partners who nagged or scolded the smoker for wanting a cigarette weren't as effective as those who were positive and reinforced the smokers' desire not to light up, Dr Lichtenstein adds.

He admits the partners weren't trained "as vigorously" as possible, but they still managed to learn enough skills to help. A partners' manual has been prepared to help offset that shortcoming in future studies, he says.

Dr Lichtenstein and colleagues are currently doing a one-year follow-up to the experiment. They will also attempt to replicate the results.

Youth and drugs is focus of two-day CAF workshop

TORONTO — Youth and Substance Abuse is the focus of a two-day workshop being organized by the Special Interest Group in Program Evaluation (SIGPE), of the Canadian Addictions Foundation (CAF).

The group, whose 26 members are interested in program evaluation in the addictions field, has scheduled the event for May 31-June 1, 1984, at the Addiction Research Foundation (ARF), Toronto, says Brian Rush, chairperson.

Mr Rush, a scientist with the Research Centre for Regional Programs, ARF, University of Western Ontario, London, says the 1984 workshop will be in four parts: driving while impaired; alcohol and drug education; trends in the epidemiology of alcohol and drug education; and legal disposition of alcohol and drug cases in the courts.

Researchers in these areas will be asked by SIGPE to present papers; only 35 participants can be accommodated.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. For further information, contact Margaret Sheppard at (416) 595-6150.

The Brick

Number: 582.
Subject heading: Drugs and youth, attitudes and values.
Details: 20 min, 16mm, color.

Synopsis: A young man in high school feels imprisoned. He is put down by a teacher for not doing an assignment correctly even though the teacher acknowledges that what he did was excellent. The film follows him through many activities: trying "pot," drinking at a school concert, working with the underground newspaper distributed in the school. Throughout, a brick, the symbol of his feelings, appears repeatedly as he contemplates throwing it and visualizes it flying destructively through the air.

General evaluation: Poor to very poor (1.7). Although this is a contemporary film, the assessment group had difficulty interpreting its message and had reservations about its editing.
Recommended use: With a resource person could provoke discussion with 15 to 18 year olds.

Alcohol: The Social Drug

Number: 581.
Subject heading: Alcohol and alcoholism overview.
Details: Four 10-min filmstrips and cassette tapes.
Synopsis: The four filmstrips attempt to cover all areas of alcohol use and abuse. They discuss the composition of alcoholic beverages, their history and current patterns of use, their effects, and the choices related to decisions to drink.
General evaluation: Fair (3.4). Although these filmstrips contained good information, the assessment group took exception to some statements.
Recommended use: With a resource person, could be helpful to audiences 15 years and older.

Alcohol and Alcoholism

Numbers: 583.
Subject heading: Alcohol and alcoholism overview.
Details: Four 20-min filmstrips with cassette tapes.
Synopsis: The four filmstrips are entitled: 1) History of a Drug, 2) Alcohol's Effects on the Body, 3) Portrait of an Alcoholic, 4) Facts and Fiction about Alcohol. Together they attempt to cover all aspects of alcohol and its use.
General Evaluation: Fair (3.0). Although these filmstrips are full of good information, each strip seemed too long and repetitive.
Recommended Use: With a resource person, could benefit audiences 12 years and older.

Tobacco: The Follower's Habit

Number: 584.
Subject heading: Smoking.
Details: 15-min filmstrip with cassette tape.

Synopsis: Narrated by Art Linkletter, this filmstrip deals with the dangers of cigarette smoking and second-hand smoke. The influence of advertising is discussed to illustrate one of the many influences on young people. The filmstrip's message is: it is better not to start smoking, since it is so difficult to stop.

General evaluation: Good (3.6). This filmstrip is a good teaching aid that could produce attitudes against smoking.

Recommended use: Of benefit to audiences 8 to 15 years.

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NEWS AND DEPARTMENT

BC physicians warned of street-drug ring

VANCOUVER — Doctors here are being warned against a suspected drug ring seeking prescriptions for ingredients of a popular street-drug cocktail.

Doctors on highway routes between Vancouver and Edmonton have reported increased numbers of requests for methylphenidate (Ritalin) and pentazocine in the form of Talwin Compound-50.

An unsigned article in the Pulsimeter column of the *British Columbia Medical Journal* says the two drugs are sold on the street in a combination called "One and Ones." The combination sells for as much as $35 in Edmonton, less in Vancouver.

It is suspected physicians are falling for an organized campaign of "multi-doctoring" in the two cities and in towns in between.

Adults seeking prescriptions for Ritalin either say they are suffering from narcolepsy, a rare disorder marked by sudden attacks of sleep, or they bring with them children instructed to behave as if they were hyperactive.

Requests for Talwin may be accompanied by an alleged history of migraine or low back pain.

Patients frequently give the name of a non-existent previous doctor when asking for the prescriptions.

One and Ones are injected into a vein after dissolving the Ritalin, and the pentazocine core of the Talwin, in water. The solution is drawn into a syringe through a cigarette filter to remove the binders and fillers in the tablets.

The medical journal reminds doctors that narcolepsy and hyperactivity are relatively rare diagnoses and suggests they contact the patient's previous physician before prescribing the remedies.

It also suggests doctors substitute Talwin 50 mg for Talwin Compound-50. In Talwin Compound-50, the pentazocine is isolated in a core surrounded by a layer of acetylsalicylic acid. In Talwin 50 mg, pentazocine is distributed throughout the tablet.

Andre Foldes, PhD, director of regulatory affairs with Winthrop Laboratories, makers of Talwin, said the distribution of pentazocine throughout the tablet in the Talwin 50 mg would make it more difficult to separate the drug from the other ingredients in the tablet.

New Books

by RON HALL

Drinking in America: A History

. . . by Mark Edward Lender and James Kirby Martin

Drinking in America (**The Journal**, Aug) is explored in depth in this illustrated book. Though there have been other historical accounts, this one is intended to bring original research together with the best of the new historical and social science investigations and to put forth the authors' own interpretation of what drinking has meant to passing generations in the United States. They state that drinking behavior and popular reactions to it have both mirrored and shaped national responses to any number of social issues. The temperance crusade, in particular, was more of a functional social response to alcohol use and some of its related activities than most historians have allowed. The story commences in Plymouth (1621), traces the change from "good creature" to "demon rum" (1790-1860), discusses drinking and the war against pluralism (1860-1920), and presents drinking and the pluralist renaissance. An epilogue is devoted to the decline of temperance, drinking in modern America, the post-temperance response, and an age of ambivalence.

(The Free Press, 866 3rd Ave, New York, NY 10022. 1982. 222 p. $19.95. ISBN 0-02-918530-0)

Alcohol, Drug Abuse and Aggression

. . . edited by Edward Gottheil, Keith A. Druley, Thomas E. Skoloda, and Howard M. Waxman

The purpose of the 5th Annual Coatesville-Jefferson Conference on Addiction Research and Treatment, and of this volume, was to bring together the leading experts from the various disciplines, obtain updates on research and theory in their respective fields, initiate dialogue among them, and provide a comprehensive overview of the currently available information about the relationship between addiction and aggression. The papers have been grouped into three main sections: sociocultural perspectives, biological perspectives, and psychological perspectives. A summary and overview comprises the concluding section. Topics covered include: alcohol use and expressive interpersonal violence; lifetime criminality of heroin addicts; alcohol abuse and family violence; pharmacotherapy for violent behavior; drugs of abuse and aggression; a psychoanalytic view of substance abuse and aggression; alcohol and human physical aggression; aggression-stress-alcoholism.

(Charles C. Thomas, 2600 S 1st St, Springfield, IL 62717. 1983. 360 p. $34.50. ISBN 0-398-04787-1)

Other Books

Federal Priorities in Funding Alcohol and Drug Abuse Programs — Stimmel, Barry (ed). Haworth Press, New York, 1983. Congressional support for alcohol and substance abuse programs; evolution of the US National Institute on Alcohol Abuse and Alcoholism; federal funding of research and research training programs in alcohol abuse; US National Institute on Drug Abuse; grantsmanship, granting agencies and future prospects for grant support. 79p. Haworth Press, 28 E 22nd St, New York, NY 10010. $19.95. ISBN 0-86656-195-1

Ontario Juvenile Delinquency Statistics and Their Implications for Drug Education Programming — Magid, Simmie C. and Goodstadt, Michael S. Addiction Research Foundation, Toronto, 1983. Statistics on detected and reported juvenile delinquency in Ontario 1978-1981; discussion follows each statistical section including police statistics, court statistics, drug- and alcohol-related charges, corrections statistics. 73p. Addiction Research Foundation, Marketing Services, 33 Russell St, Toronto, ON M5S 2S1. $7.50. ISBN 0-88868-079-1

Prevention of Intellectual Handicaps — Fotheringham, John B.; Hambley, Walter D.; and Haddad-Curran, Harriet W. Ontario Association for the Mentally Retarded, Toronto, 1983. Maternal lifestyle during pregnancy and intellectual development in the child; social environment and intellectual development; environmental agents and mental retardation; inherited factors in intelligence; regionalized system for pregnancy, birth and neonatal care; priorities in prevention. Index. 220p. Ontario Association for the Mentally Retarded, 1376 Bayview Ave, Toronto, ON M4G 3A3. $10. ISBN 0-9691385-0-4

First non-alcoholic woman is named to AA board

TORONTO — For the first time in the history of Alcoholics Anonymous (AA), a non-alcoholic woman has been elected to serve on its board.

Joan K. Jackson, PhD, a Canadian-born educator and researcher with extensive background in alcoholism studies, will serve no more than three consecutive three-year terms as non-alcoholic trustee of the General Service Board of AA. She succeeds Milton Maxwell, PhD, who retired last year.

Dr Jackson, who became a citizen of the United States in 1958, has degrees in sociology and anthropology, and has taught at McGill University, Montreal, and the University of Washington Medical School in Seattle. She joins six other non-alcoholics on the 21-member board, which reports to AA's General Service Conference, the body that guard's AA traditions and directs its key service affairs.

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Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

Canada

Group Therapy Course — Jan 9-13, 1984, Toronto, Ontario. Information: Doreen Ross, Addiction Research Foundation (ARF), School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Fundamental Concepts Course in Addictions — Jan 16-19, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Perspectives on Employee Assistance Programming Course — Jan 23-26, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Annual Meeting of the Ontario Psychiatric Association — Jan 26-28, 1984, Toronto, Ontario. Information: Donna Gray, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Pharmacology and Drug Abuse Course — Feb 6-8, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

1984 Professional Practice Conference — Feb 6-8, 1984, Toronto, Ontario. Information: Canadian Society of Hospital Pharmacists, Ste 303, 123 Edward St, Toronto, ON M5G 1E2.

37th Annual Convention of the Ontario Psychological Association — Feb 9-11, 1984, Toronto, Ontario. Information: Dr Pierre Ritchie, Convenor, OPA '84, 1407 Yonge St, Ste 402, Toronto, ON M4T 1Y7.

National Joint Conference on Nursing Education and Practice — Feb 9-12, Ottawa, Ontario. Information: Jocelyne Robert-Tanguay, Conference Coordinator, Canadian Nurses Association, 50 The Driveway, Ottawa, ON K2P 1E2.

Prevention Strategies Workshop — Feb 20-22, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Workshops 1983-84: Employee Assistance Program Management Update — Feb 22-24, 1984, Toronto, Ontario. Information: Yvonne Johns, department head, department of Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Relaxation and Stress Management Workshop — March 1-2, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Toughlove Weekend Workshop for Parents and Professionals — March 3-4, 1984, Vancouver, British Columbia. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania 18960.

Detox Training Program — March 5-9, April 30-May 4, 1984, Toronto, Ontario. Information: Diane Hobbs, Coordinator of Detox and Rehabilitation Programs, ARF, 33 Russell St, Toronto, ON M5S 2S1.

Circuit and Rural Court Justice in the North — March 11-16, 1984, Yellowknife, Northwest Territories. Information: The Northern Conference, c/o Continuing Studies, Simon Fraser University, Burnaby, British Columbia V5A 1S6.

Instructional Methodologies Course — March 12-16, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

1984 Canadian Addictions Foundation Atlantic Regional Conference, Families and Drug Dependencies New Problems, New Challenges — April 29-May 3, 1984, Halifax, Nova Scotia. Information: Nova Scotia Commission on Drug Dependency, 5668 South St, Halifax, NS B3J 1A6.

Introductory Addictions Management Course — May 14-16, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Alcohol, Other Drugs and the Law Course — June 4-6, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Summer Fundamental Concepts Course — July 16-19, 1984, Toronto, Ontario. Information: Doreen Ross, ARF, School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-9, 1985, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th floor, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

United States

"Healing Adult Children of Alcoholics, Laughter, Creativity and Play" — Dec 6-8, Minneapolis, Minnesota. Information: Children Are People, Inc, 1599 Selby Ave, St Paul, MN 55104.

Student Assistance Programming — Dec 12-16, Milwaukee, Wisconsin. Information: Candee Brandis, Training department, De Paul Rehabilitation Hospital, 4143 S 13th St, Milwaukee WI 53221.

Alcoholism — The Search for the Sources — Jan 18-20, 1984, Charlotte, North Carolina. Information: Elaine Woody, Center for Alcohol Studies, School of Medicine, The University of North Carolina at Chapel Hill, 335 Medical School Building, 207H, Chapell Hill, NC 27514.

Update and Training Workshop on Alcoholism Clinical and Treatment Planning Requirements of the Joint Commission on Accreditation of Hospitals — Jan 19-20, 1984, Orlando, Florida. Information: Michael Q. Ford, Executive Director, NAATP, 2082 Michelson Dr, Ste 200, Irvine, California 92715.

Toughlove Weekend Workshop for Parents and Professionals — Jan 28-29, 1984, Baltimore, Maryland. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania 18960.

5th Training Institute on Addictions — Feb 2-7, 1984, Clearwater Beach, Florida. Information: The Institute for Integral Development, PO Box 2172-T, Colorado Springs, Colorado 80901.

Toughlove Weekend Workshop for Parents and Professionals — Feb 11-12, 1984, Santa Clara, California. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania 18960.

Toughlove Weekend Workshop for Parents and Professionals — Feb 18-19, 1984, Anaheim, California. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania 18960.

Pharmacology and Drug Dependence — Feb 27-28, 1984, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Toughlove Weekend Workshop for Parents and Professionals — March 10-11, 1984, Chicago, Illinois. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania 18960.

International PRIDE Conference for Adults and Youth — March 22-24, 1984, Atlanta, Georgia. Information: PRIDE, 100 Edgewood Ave, Ste 1216, Atlanta, Georgia 30303.

Toughlove Weekend Workshop for Parents and Professionals — March 24-25, 1984, New Brunswick, New Jersey. Information: Susan Wachtel, Community Service Foundation, PO Box 70, Sellersville, Pennsylvania, 18960.

Health and Addictions Seminar — March 25-30, 1984, Park City, Utah. Information: The Institute for Integral Development, PO Box 2172-T, Colorado Springs, Colorado 80901.

Sexuality and Alcohol/Drug Dependence — March 26-28, 1984, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205.

Ruth Fox Course for Physicians — Apr 12, 1984, Detroit, Michigan. Information; Claire Osman, Course Coordinator, American Medical Society on Alcoholism, 733 3rd Ave, New York, New York 10017.

American Medical Society on Alcoholism — April 12-15, 1984, Detroit, Michigan. Information: American Medical Society on Alcoholism, 733 3rd Ave, New York, New York 10017.

National Alcoholism Forum of the National Council on Alcoholism — April 12-15, 1984, Detroit, Michigan. Information: Angela Masters, 733 3rd Ave, New York, New York 10017.

15th Annual Medical-Scientific Conference of the National Alcoholism Forum, "Clinical Applications of Alcoholism Research" — April 12-15, 1984, Detroit, Michigan. Information: Medical-Scientific Conference Coordinator, AMSA, 733 3rd Ave, 14th floor, New York, New York 10017.

Introduction to Alcohol/Drug Counselling — April 25-27, 1984, Indianapolis, Indiana. Information: Kay F. Brooks, Intervention Associates, 4328 N Park Ave, Indianapolis, IN 46205

46th Annual Scientific Meeting of the Committee on Problems of Drug Dependence — June 4-6, 1984, St Louis, Missouri. Information: Dr Joseph Cochin, department of Pharmacology, Boston University, School of Medicine, 80 E Concord St, Boston, Massachusetts 02118.

2nd Congress of the International Society for Biomedical Research on Alcoholism — June 24-29, 1984, Santa Fe, New Mexico. Information: Richard A. Deitrich, department of Pharmacology, Alcohol Research Center, University of Colorado, Health Sciences Center, 4200 East 9th Ave, Denver, Colorado 80262.

Abroad

2nd International Congress on Drugs and Alcohol — Dec 18-22, Tel Aviv, Israel. Information: Congress Secretariat: Peltours Ltd, Congress department, PO Box 394, Tel Aviv, 61003 Israel.

An International Conference on Alcoholism and Drug Addiction — Apr 2-7, 1984, Canterbury, England. Information: Conference Secretary, Broadway Lodge, Oldmixon Rd, Weston-super-Mare, Avon, BS24 9NN, England.

6th International Conference on Alcohol Related Problems — April 8-13, 1984, Liverpool, England. Information: Conference Secretary, MLCCA, 1st Fl, The Fruit Exchange, Victoria St, Liverpool L2 6QU, England.

30th International Institute on the Prevention and Treatment of Alcoholism — Athens, Greece, May 27-June 2, 1984. Information: International Council on Alcohol and Addictions, Case postale 140, 1001 Lausanne, Switzerland.

15th World Congress of Rehabilitation International — June 4-8, 1984, Lisbon, Portugal. Information: National Secretariat for Rehabilitation, International Fair of Lisbon, Praca das Industrias, 1399 Lisbon-Codex, Portugal.

4th World Congress of Alternative Medicine — July 13-15, 1984, Amsterdam, Netherlands. Information: Dr Anton Jayasuriya, Secretary Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

11th International Conference of Social Gerontology — Oct 16-19, 1984, Rome, Italy. Information: International Center of Social Gerontology, 91, rue Jouffroy, 75017 Paris, France.

2nd Inter-American Symposium on Health Education — Nov 4-9, 1984, Acapulco, Mexico. Information: Symposium Steering Committee, c/o NARO, PO Box 2305, Station D, Ottawa, Ontario, K1P 5K0.

12th International Conference on Health Education — Sept 1-6, 1985, Dublin, Ireland. Information: Dr H. D. Crawley, Director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

AIDS . . . a medical mystery story

(from page 1)

The etiology of AIDS, is unknown, though early epidemiological evidence suggests a transmissible or infectious agent, with a virus the most likely candidate, says Randall Coates, MD, co-principal investigator of a recently-approved AIDS study at the University of Toronto (U of T). Early evidence suggests AIDS, like hepatitis B virus, is transmitted by blood or semen, he says.

"There is no strong evidence to suggest saliva as a mode of transmission," he adds.

Among IV drug abusers, needle sharing is considered by researchers to be the principal culprit in spreading the syndrome.

Some facts:

• As of Oct 24, the Laboratory Centre for Disease Control (LCDC) in Ottawa had identified 45 cases of AIDS in Canada. This represents roughly 1.8% of the US total, and approximately 4.5% of the 1,010 cases confirmed in New York City.

• Four IV drug abusers have been identified among Canada's 45 AIDS cases, one of whom does not belong to other risk groups.

• The number of AIDS cases in the US has doubled every six months. In Canada, the number of AIDS cases has grown by 73% during the past 8½ months (to Oct 24). "For some inexplicable reason, the number of cases seems to be reaching a plateau," says Colin Soskolne, PhD, associate professor of medicine at the U of T and principal investigator of the U of T AIDS study team. (Dr Soskolne and LCDC field epidemiology division chief Gordon Jessamine, MD, caution, however, that the Canadian statistical base remains too small to draw final conclusions.)

• Though fear persists about contracting AIDS through casual contact, researchers stress there's not a shred of evidence that AIDS can be transmitted other than by sexual contact, sharing of contaminated needles, and infusion of blood or blood products from individuals with AIDS or ARC (AIDS Related Complex, or pre-AIDS).

• Dr Jessamine says the number of cases identified to date in Europe is 267. This represents approximately 10.6% of the US total. The CDC's latest figures show only 156 AIDS cases from 21 other countries around the world.

• The US National Institute on Drug Abuse (NIDA) estimates that 77% of IV drug abusers with AIDS come from New York or New Jersey; only 9% are from California. "In New York and New Jersey, there are high rates of IV drug use, lots of 'shooting galleries,' and institutionalized sharing of needles," explains Marvin Snyder, PhD, director, division of pre-clinical research, NIDA. "These things are not as popular in California." Canadian addiction professionals and physicians familiar with IV drug abusers suggest needle sharing is less common in Canada, and 'shooting galleries' are virtually non-existent.

'No health care worker treating AIDS has contracted the syndrome'

• Says the Ontario ministry of health: "Initial AIDS symptoms are non-specific and include extreme fatigue, persistent or intermittent fever, night sweats or chills, weight loss, diarrhea, abdominal cramps, and lymphadenopathy (swollen lymph nodes, often in the neck, under the arms, or in the groin areas)." The ministry says guidelines for handling hospitalized AIDS patients, and dealing with specimens in the province's laboratories, "are generally consistent with those for hepatitis B." It adds that "AIDS appears to be less contagious than hepatitis B."

• At present, the ministry says there are no reliable lab tests for diagnosing AIDS, "although abnormalities in several immunologic tests may be present." Further, "immunoglobulin may be increased and the T helper/T suppressor cell ratio may be reversed."

• In the absence of a cure for AIDS, health care workers across North America have focused their efforts on preventive measures, advising high risk groups to cut down on sexual activity with multiple partners, and to avoid sharing needles.

• *The New York Times*, reports that public health officials in New York, Denver, and Los Angeles say fear of AIDS has indirectly reduced the incidence of venereal disease among male homosexuals. Dr Jessamine, of the LCDC, says a similar trend has been observed in Toronto.

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The barrage of media attention devoted to AIDS and the gay community has obscured its occurrence among the second largest risk group: IV drug users. Marion McIntosh, MD, head of ambulatory services, Addiction Research Foundation (ARF), and Emear McKaigney, MD, resident, family and community medicine at the ARF, outlined AIDS-related anxieties among patients and staff at a recent Grand Rounds presentation at the ARF.

Dr McIntosh said two patients who presented at recent ARF family and community medicine clinics expressed fear they had contracted AIDS. One was a 30-year-old amphetamine abuser who had used cocaine intravenously until the previous month, and the other a 42-year-old homosexual alcoholic whose friend died after contracting AIDS. Neither presented with AIDS or ARC symptoms, she said.

More importantly, perhaps, Dr McKaigney said 47 of 50 ARF staff members deemed at risk of being exposed to hepatitis B recently declined an offer of hepatitis B vaccine. The "vast majority" refused for fear of contracting AIDS, she said.

Hepatitis B vaccine is manufactured from serum, some of which is collected from male homosexuals who are carriers of the hepatitis B surface antigen, explains Paul Devenyi, MD, head of medical services at the ARF, and chairman of the ARF's infection control committee.

"There is no reason to believe AIDS would be transmitted by vaccine even if some of the donors had AIDS," says Dr Devenyi, indicating the manufacturing process would destroy any viral agent. "But we are not going to push anybody, even though the risk of contracting hepatitis B in a hospital like the one at the ARF is much greater than getting AIDS."

Indeed, speculation among epidemiologists and other researchers about the pattern of AIDS transmission among IV drug abusers revolves around the hepatitis B model, with blood and semen the suspected modes of transmission.

Explains Dr Coates: "Anyone who contracts hepatitis B passes through a three- or four-month incubation period, during which they are capable of transmitting the virus through appropriate kinds of contact, either sexually, through semen, or through blood, if the carrier's blood gets into another's blood stream.

"Most will develop an appropriate immune response and will cease being capable of transmitting the agent. But about 10% of all who are infected with hepatitis B become chronic carriers of the virus, possibly for life. And only about 25% who get the virus exhibit the symptoms associated with hepatitis B. It is therefore possible for those who do not experience the symptoms to transmit the agent without knowing it, given the appropriate conditions.

"If a similar model is operative in the syndrome we call AIDS," says Dr Coates, "there is indirect epidemiological evidence that AIDS can be transmitted from someone who feels healthy, yet is infected with the agent and in the incubating phase."

To carry the hypotheses one step further, "It's also possible that people have contracted AIDS and recovered," he says.

Dr Coates' assertions echo those of James Curran, MD, head of the AIDS task force at the CDC in Atlanta. He suggests that only about 10% of those exposed to AIDS develop the full-blown syndrome.

"The good thing is that means perhaps the mortality rate is much lower than the 40% to 80% reported," he told a meeting of the International Society for STD (sexually transmitted diseases) Research in Seattle. "The bad thing is it means that there are probably several times as many people affected with AIDS, and perhaps carriers of AIDS, than we currently know."

The pattern and degree of infectious transmission is one of three areas to be explored by the U of T AIDS study group, recently awarded $100,000 from the Ontario ministry of health's $500,000 AIDS research fund established in July. The team will also examine risk factors (using people with AIDS and ARC, and a control group with no symptoms), and possible intervention strategies, says Dr Soskolne. "We hope to present preliminary results within one year."

The U of T study is not concerned primarily with IV drug users, however, and the study group does not include a professional from the addictions field.

With US cases continuing to double every six months, the syndrome may be far more widespread than originally conceived. But researchers speculate that, just as New York City, with 1,048 cases, San Francisco, with 311, and Los Angeles, with 186, are viewed as focal points for AIDS transmission because of the sexual habits of some homosexual and bisexual males in those cities, so too is the incidence of IV drug abusers with AIDS greater where needle sharing is common — namely, the northeastern states of New York and New Jersey.

Says Dr Coates: "This is all anecdotal, of course, but the tendency in Canada seems to be against sharing needles."

Moreover, there is a vast difference between the US and Canada in the base populations of IV drug users.

The latest Canadian statistics (1981), published by the Bureau of Dangerous Drugs (BDD), Health Protection Branch, Health and Welfare Canada, identify 14,157 habitual narcotic drug abusers in Canada. It is not known how many from this group are IV drug abusers, says Erihoi Malyniwsky, chief, information services division, BDD.

In the US, a NIDA spokesman estimates the IV drug-abusing population at about 600,000 — or approximately 43 times the Canadian total of known narcotic drug abusers.

Quite simply, the incidence of IV drug abuse —and needle sharing, by implication— increases dramatically south of the border.

"There are places now where an addict can go and rent his equipment," explains the NIDA's Dr Snyder. "So, he need not carry any incriminating evidence on his person. What it amounts to is institutionalized sharing of needles. It has occurred during the past three or four years, tied, perhaps coincidentally, with the onset of AIDS."

Interestingly, an addictions professional in the US, who asked to remain anonymous, claims that the CDC "is now trying to get a more precise cause of death" for the many overdose victims who have died in New York City during the past year. He says records show that "10% of deaths among addicts involved PCP" — the opportunistic infection most commonly linked with IV drug abusers who contract AIDS. "If those people had died today, they would be diagnosed as AIDS victims," he says. "There is a possibility that AIDS has been around for quite a while. We just didn't know it."

'Attention to AIDS and the gay community obscures its occurrence among IV drug users'

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The marked statistical and behavioral differences between IV drug abusers in Canada and the US suggests the incidence of AIDS among addicts in Canada, as among homosexuals, may never approach the levels found in the US, even on a per capita basis.

But not all observers buy that logic.

Says David Smith, MD, medical director of San Francisco's Haight-Ashbury Free Medical Clinic: "I always run into these statistical differences between Canada and the US. It could mean that our case finding approach is more aggressive. Or maybe AIDS just hasn't hit your area yet. We really need more time and study."

Dr Jessamine agrees it is too early to make generalizations. "Remember, there are still only three provinces (Ontario, British Columbia, and Alberta) where AIDS is a notifiable condition."

Nevertheless, he admits to a "gut feeling," as do several other health care professionals who work closely with the gay community, that lifestyle differences between Canada and the US will slow the spread of AIDS here. Put simply, many believe Canada's gays are not as sexually active as their US counterparts, just as addictions workers attest to less needle sharing.

But this is speculation. Dr Jessamine and others stress a great deal of research needs to be done.

In the US, where AIDS has hit with far greater impact, the federal government has committed $25.15 million in AIDS funding to various agencies for fiscal 1983, says CDC public affairs specialist Charles Fallis. Allocations for 1984 have reached $17.66 million, with an additional $22 million under active consideration.

The NIDA alone, armed with a $400,000 grant, will focus its research on AIDS and addicts.

Dr Snyder offers an unusual hypothesis: "We're strongly considering the possibility that AIDS itself is some sort of opportunistic infection that only attacks those who already have an altered immune system," he says. "In other words, can AIDS be transmitted solely by contaminated needles, or is there a predisposed susceptibility (to AIDS) among some addicts? There is some evidence that IV drug users have an altered immune system already."

In Canada, a National Advisory Committee to coordinate efforts to deal with AIDS was formed in August at the request of federal Health and Welfare Minister Monique Begin and the (Ontario) ministry of health's Advisory Committee on AIDS, established earlier in the summer. The national committee met for the first time Sept 30.

Although Health and Welfare Canada is considering several research proposals, none has received approval yet, says Greg Smith, director, research administration, national health research and development program.

The Ontario body, perhaps reflecting interest shown by Health Minister Keith Norton, has taken a more aggressive approach.

In response to research priorities established by the provincial committee (epidemiological studies, development of diagnostic tests, examination of treatment methods), the ministry of health awarded $100,000 to the U of T AIDS study group, and $12,500 to University of Western Ontario MD, Hon-Sum Ko, "to examine the feasibility of measuring alpha-thymosin in order to test for AIDS." (Alpha-thymosin is a hormone that promotes production of cells responsible for the body's immunity, the ministry says.)

The ministry is also contributing $15,500 toward two films on AIDS.

The Medical Research Council has funded the largest AIDS research project in Canada to date: a three-year, $523,659 study of AIDS and hemophiliacs, under the direction of Montreal MD, Phil Gold.

The AIDS Committee of Toronto (ACT) received $62,400 from the Canadian Ontario Employment Development Program, under the auspices of the federal ministry of employment and immigration, and the province's ministry of labor.

The ACT has been instrumental in educating the public and medical community alike, and it helped establish an AIDS hotline for Ontario physicians. But it does no research.

As for study of AIDS and IV drug abusers, not a single Canadian study has been proposed to date, say federal and provincial authorities contacted by **The Journal**.

Meanwhile, definitive answers about cause and cure of the mystery syndrome remain elusive. And fear of AIDS continues to gnaw at the public.

'In Canada, the incidence of AIDS among addicts, as among homosexuals, may never approach the levels found in the US, even on a per capita basis'